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**EVALUATION OF THE GRANT PROGRAM FOR  
RURAL HEALTH CARE TRANSITION  
SIXTH SEMI-ANNUAL PROGRESS REPORT**

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## EXECUTIVE SUMMARY

Congress charged the Health Care Financing Administration (HCFA) with implementing a program of Rural Health Care Transition (RHCT) grants (Omnibus Budget Reconciliation Act of 1987: P.L. 100-203) and expanding the program (Omnibus Budget Reconciliation Act of 1989: P.L. 101-239). The goal of this program is to help small rural hospitals improve their long-term financial stability and management capacity.

The program was implemented in September 1989 and expanded in September 1990 and September 1991. Over the last 3 years, 583 RHCT grants were awarded to small rural hospitals: 184 in 1989, 212 in 1990, and 187 in 1991. Thus, close to one-third of the small rural hospitals in the United States have received a grant. While the vast majority of the grantees (529) have 3-year grants and are progressing with their projects, 31 have completed their projects, and 23 gave up their grants--9 because they closed their hospitals.

The legislation mandated that the HCFA Administrator report to Congress every 6 months on the progress of the program. This is the sixth semi-annual report. In this report, we focus on two topics: the services implemented by the 1989 grantees in the 30 months since they received their grant awards, and the nature and progress of the consortium projects funded in 1989 and 1990. The report also describes the progress of the 1989 grantees after 30 months, the 1990 grantees after 18 months, and the 1991 grantees after 3 months. These progress reports are based on monitoring reports submitted by the 1989 and 1990 grantees covering the 6-month period from September 30, 1991, through March 31, 1992, and the monitoring reports submitted by the 1991 grantees for the 3-month period from September 30, 1991 through December 31, 1991.

### Grantee Status

The status of 1989, 1990, and 1991 grantees as of March 31, 1992, is as follows:

STATUS OF 1989, 1990, AND 1991 GRANTEEES AS OF MARCH 31, 1992

Status	1989	1990	1991
Months since Award	30	18	6
Continuing	145	201	183
Completed	29	2	0
Voluntarily Terminated Grant	5	6	1

Status	1989	1990	1991
Involuntarily Terminated Grant	1	0	1
Hospital Closed	4	3	2
Total Awards	184	212	187

Eight of the hospitals that received grants in 1989 have closed (although four continue as grantees providing primary care or long term care), three of the 1990 grantee hospitals have closed, and two of the 1991 grantees have closed. These closings imply an annualized closure rate of about 2 percent, which is similar to that of small rural hospitals nationwide in 1990.

### 1989 Grantee Progress

The 1989 grantees have been operational for 30 months--6 months longer than the time period allotted in their original award. As a result of this long operational period, substantial progress has been made, even with projects that originally fell behind schedule. The 1989 grantees have used their RHCT grant funds to implement or upgrade 79 patient services, recruit 104 physicians, complete 53 market analyses and complete 57 construction or renovation activities.

Grantees reported on the number of patients using 54 of the 79 patient services implemented. Over 13,000 patients per month now receive services at their local hospital who otherwise would have had to travel for the service or done without.

Over 60 percent of the patient services implemented are outpatient services, 11 percent are inpatient services, 10 percent are transportation services, and the remainder are well-patient/social services. Almost all of the inpatient projects (seven out of nine) developed inpatient mental health services. The most frequently implemented outpatient services are physician services, home health agencies and hospices, and diagnostic services.

The 1989 grantees implemented inpatient services sooner than outpatient or transportation services. Over half of the inpatient projects were implemented within 1 year of receiving the award whereas almost half of the outpatient and transportation projects took over 2 years to implement. The reason for the shorter time to implementation is that more of the inpatient services were planned before the grantees received their grants.

The grantees whose goal was to recruit and retain physicians have mostly done so; however, their recruiting success has barely increased their staff size. During the first 2 years of the program, 104 physicians have been recruited by the 53 grantees that devoted funds to physician recruitment. Despite this success, 75 percent are still recruiting physicians, and



28 percent are recruiting three or more physicians. This high-level of recruiting effort is necessitated by the loss of physicians during the period. The large turnover in physician staff has resulted in an average net gain of only .45 physicians per grantee.

One goal of the evaluation of the RHCT grant program is to determine how the grantees achieve their success. Other rural hospitals will be able to learn from and replicate the grantees' projects if they know what factors were important for success, and what problems were encountered and how these problems were surmounted.

The grantees cite two key reasons for the successful implementation of their projects. The first is the availability of funds--over 62 percent of the 1989 grantees cited the availability of funds--in particular, the RHCT grant funds--as the reason for their success. The second key factor is that the project meets a real need in the community--many projects are realizing higher than anticipated utilization rates, and this has allowed the projects to become self-supporting before the end of the grant period.

The 1989 grantees report only a few problems that are still impeding their grant projects. Two problems that they continue to cite are professional recruitment and retention problems (24 percent) and funding difficulties (18 percent). The hospitals attribute their inability to attract health professionals to the small supply of health professionals willing to locate in rural areas. In addition, retaining health care administrators remains a problem, although administrative turnover has not halted grant project progress as it did in the earlier stages of the grant program. A few hospitals have delayed implementation because they depended on supplemental funds which they have not been able to raise during the economic recession.

### **1990 Grantee Progress**

Eighteen months into their projects, the 1990 grantees are most likely to have completed activities over which they have the most control: close to half of the planned equipment purchases have been made, and one-third of the projects that had planning or market analysis components had completed them. By contrast, construction and recruitment projects were the most likely to be delayed (like the 1989 grantees 1 year ago).

### **1991 Grantee Progress**

Three months into their projects, all the 1991 grantees have started their projects and the majority are on schedule. Even at this early date, grantees have completed some activities: 20 percent of the grantees recruiting health professionals and 7 percent of the grantees planning equipment purchases have done so. Like the 1990 grantees, the 1991 grantees have made substantial progress on activities over which they have a high degree of control, such as

planning and market analysis, equipment purchases, wellness programs and staff education. Despite the progress made, close to one-third of the 1991 grantees experienced start-up difficulties with their projects. The grantees reported being behind schedule principally in recruiting health professionals and establishing new services.

Over half of the hospitals that reported start-up problems had negative operating margins in fiscal year 1990. We interviewed administrators of 20 hospitals that both experienced start-up problems with their projects and had negative operating margins in 1990. Surprisingly, none of these grantees indicated that their financial difficulties contributed to their start-up problems. Instead, the grantees indicated that their projects are behind schedule because of two other reasons--difficulties recruiting health professionals and organizational instability due to their small size.

The grantees attribute their recruiting delays to the shortage of health care professionals--especially physicians--who are willing to practice in rural areas with heavy on-call burden and low salaries. Rural hospitals that are on the fringe of urban areas have difficulty attracting physicians who are willing to refer patients to the small rural hospital rather than the larger, better equipped urban hospitals located nearby. Rural hospitals that are extremely isolated--those that are located as much as 4 to 5 hours from an urban area--cite harsh winters, few forms of social entertainment, and extremely burdensome on-call schedules as the factors discouraging health care professionals from locating in their towns.

Many hard-pressed hospitals are employing alternative strategies to address their health professional needs. Some hospitals are downsizing their facilities, and others are opting to recruit foreign-born health care professionals when previously they may have preferred U.S.-born professionals. Almost half of the hospitals interviewed have at least one foreign-born physician on staff and one-quarter of the hospitals interviewed are either downsizing or considering downsizing their facility.

Organizational instability due to rural hospitals' small size often affected the progress of many hospitals' projects. Typically a staff disruption, either positive (for example, introduction of an experienced administrator) or negative (for example, physician bickering), affected the grantees' ability to keep their project on schedule in the short run.

### **Consortium Projects**

A consortium is an organization that provides independent rural hospitals with a structural framework to undertake joint activities, while maintaining local autonomy. As of January 1, 1989, (9 months before the RHCT program began), 127 rural hospital consortia were operating in 43 States. Since the start of the RHCT grants program in September 1989, HCFA has awarded 41 grants to consortia, making the RHCT grant program the largest

funder of rural health consortia. The most common goals of the 1989 and 1990 grantee consortia are joint provision of health care services, joint provision of health care professional education, and health care professional recruitment.

In 1989, the average rural hospital consortium nationwide had operated for 5.7 years, and 40 percent had operated for less than 3 years. Among the 1990 RHCT grant winners, 60 percent of the funded consortia were newly established to apply for the RHCT grants program--up from 36 percent of the 1989 consortia. These consortium members communicate frequently and effectively within their consortia--66 percent meet at least once a month, while the nationwide average in 1989 was nine meetings per year.

Eighty percent of the 1990 RHCT consortium members are independent hospitals--a similar proportion as the 1989 grantees. However, 41 percent of the 1990 consortium grantees are managed under contract, compared to 21 percent of the 1989 consortium grantees, suggesting that contract management firms may be more enthusiastic about consortium participation as a way to improve hospital performance.

The majority of the 1989 RHCT consortia and over one-third of the 1990 consortia report having implemented joint projects. Consortia have made the most substantial progress with education projects, but they have also implemented a joint management information system, a joint quality assurance system, staff sharing pools, and a geriatric assessment program. Four of the 1990 grantees, however, are still planning their projects, indicating that forming coalitions and reaching agreement can take a substantial period of time.

An alternative to joining a rural hospital consortium is to consolidate with other hospitals. By consolidating, underutilized hospitals can share the costs of building maintenance, administrative expenses and other fixed costs, thus lowering costs and increasing profitability. However, hospital consolidation faces numerous impediments, even when it is financially advantageous for the institutions involved. Few of the RHCT grantees have seriously considered consolidating. Of the active 1989 grantees, only one grantee has actually consolidated. None of the 1990 grantees has consolidated.

### Grant Expenditures to Date

Grant expenditures as of March 31, 1992 were as follows:

Grant Year	Expenditures Through:	Amount Spent	Number of Grantees Reporting	Percent of Obligated Funds
1989	March 31, 1992	\$13,795,415	149	61 %
1990	March 31, 1992	\$10,544,084	171	59 %
1991	December 31, 1991	\$1,173,241	183	15 %

## **I. INTRODUCTION**

### **A. LEGISLATIVE HISTORY AND PURPOSE OF THE GRANT PROGRAM**

Congressional concerns about the financial and operational viability of rural hospitals and the access of rural residents to health care led to the enactment of the Grant Program for Rural Health Care Transition. In the legislation, Congress mandated that the Health Care Financing Administration (HCFA) "establish a program of grants to assist eligible small rural hospitals and their communities in the planning and implementation of projects to modify the type and extent of services such hospitals provide in order to adjust for one or more of the following factors:

- (1) Changes in clinical practice patterns
- (2) Changes in service populations
- (3) Declining demand for acute-care inpatient hospital capacity
- (4) Declining ability to provide appropriate staffing for inpatient hospitals
- (5) Increasing demand for ambulatory and emergency services
- (6) Increasing demand for appropriate integration of community health services
- (7) The need for adequate access to emergency care and inpatient care in areas in which a number of underutilized hospital beds are being eliminated."<sup>1</sup>

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<sup>1</sup>Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203), Section 4005(e).

The legislation further stipulated that "a grant may not exceed \$50,000 a year and may not exceed a term of two years."<sup>2</sup> Funds may be spent for any expense incurred in planning and implementing the project, with two exceptions: no part of the grant funds may be used to retire debt incurred before September 15, 1989,<sup>3</sup> and not more than one-third of the grant funds may be used to cover capital-related costs. The legislation mandated that grantees be non-Federal, nonproprietary, short-term, general acute care hospitals with fewer than 100 beds. And grantees were to be paid as rural hospitals under Medicare's prospective payment system.

In the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239), Congress enacted two modifications to the Rural Health Care Transition (RHCT) grants program. First, the grant period for hospitals that received an award after fiscal year (FY) 1989 was extended from 2 to 3 years. Second, hospitals that use their grants to convert to rural primary care hospitals are not limited to the one-third capital expenditure maximum. In addition, Congress provided \$17.8 million to fund the second year of the FY 1989 grants and the first year of the FY 1990 grants. In FY 1991, Congress provided an additional \$24.4 million to fund the third year of the FY 1989 grants, the second year of the FY 1990 grants, and the first year of the FY 1991 grants.

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<sup>2</sup>Section 4005(e)(6) of the Act.

<sup>3</sup>The date of the grant award.

## **B. THE NUMBER AND STATUS OF GRANTEES**

A total of 559 hospitals have participated in the RHCT grants program since its inception in 1989 (see Figure I.1). This represents 29 percent of the total number of eligible rural hospitals nationwide.<sup>4</sup> Most participating States have over one-third of their eligible rural hospitals winning RHCT grants. Most of these States are located in the Midwest, West and South census regions.

Texas has the largest number of hospitals participating in the RHCT grants program, with 53 rural hospitals having won grants over the life of the program. The large number of Texas grantees reflects the fact that the State has 187 eligible rural hospitals, representing 10 percent of eligible rural hospitals nationwide. In contrast, Connecticut, Hawaii, and Puerto Rico have the fewest number of hospitals participating in the RHCT grants program--each with one hospital. This small number reflects the number of eligible rural hospitals in those States: Connecticut has one eligible rural hospital, Puerto Rico has five eligible rural hospitals, and Hawaii has nine eligible rural hospitals.

### **1. 1989 Grantees**

The majority of the 184 RHCT grants HCFA awarded on September 15, 1989, remain active 30 months later (see Table I.1). As of March 31, 1992, 143 hospitals are still operating 145 grant projects. The continuing hospitals are listed in Appendix A.

During the past 6 months, only one hospital, Methodist Hospital in South Dakota, has left the grant program without completing its project. The hospital consolidated with St. Joseph

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<sup>4</sup>There are currently 1,939 eligible rural hospitals nationwide.

**FIGURE I.1**  
**NUMBER AND PERCENT OF ELIGIBLE HOSPITALS**  
**AWARDED RURAL HEALTH CARE TRANSITION**  
**GRANTS SINCE 1989 BY STATE**

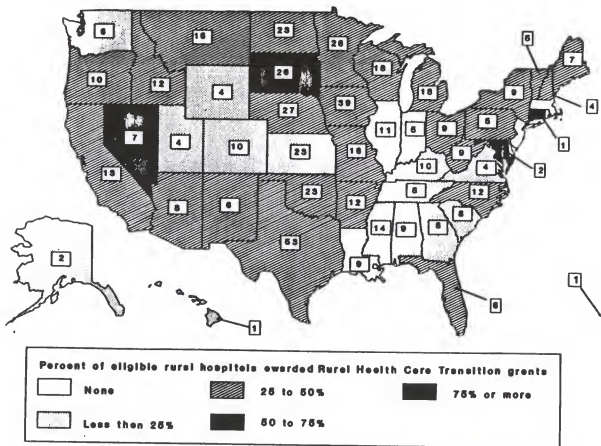


TABLE I.1  
1989 GRANTEE STATUS

	Time Period						Cumulative 9/15/89 - 3/31/92
	At Award 9/31/89	Month 6 3/31/90	Month 12 9/30/90	Month 18 3/31/91	Month 24 9/30/91	Month 30 3/31/92	
Number of Grantees (Hospitals) at Start of Period	184 (181)	182 (179)	181 (178)	172 (170)	171 (169)	149 (147)	184 (181)
Number of Voluntary Terminations in Period	2 <sup>a</sup> (2)	0	2 <sup>a</sup> (2)	0	0	1 <sup>a</sup> (1)	5 (5)
Number of HCFA Terminations in Period	0	0	1 <sup>b</sup> (1)	0	0	0	1 (1)
Number of Hospitals Ceasing Operations and Terminated in Period	0	1 <sup>c</sup> (1)	1 <sup>i</sup> (1)	1 <sup>i</sup> (1)	1 <sup>m</sup> (1)	0	4 (4)
Number Completed in Period	0	0	5 <sup>j</sup> (4)	0	21 <sup>n</sup> (21)	3 <sup>p</sup> (3)	29 (28)
Number Remaining at End of Period	182 (179)	181 (178)	172 (170)	171 (169)	149 (147)	145 (143)	145 (143)
Other Changes:							
Ceased hospital operations but is still a grantee	1 <sup>b</sup> (1)	2 <sup>d</sup> (2)	1 <sup>k</sup> (1)	0	0	0	4 (4)
Changed scope	0	1 <sup>e</sup> (1)	0	0	0	0	1 (1)
Other	0	1 <sup>f</sup> (1)	0	0	0	0	1 (1)

<sup>a</sup>Breckinridge Memorial Hospital, Kentucky  
Arkansas Memorial Hospital, Arkansas

<sup>b</sup>Caledonia Health Care Center, Minnesota

<sup>c</sup>Salamanca District Hospital, New York

<sup>d</sup>Presbyterian Family Health Care, New Mexico  
St. Mary's Hospital and Home, Minnesota

<sup>e</sup>Presbyterian Family Health Care, New Mexico

<sup>f</sup>Webster General Hospital, Mississippi

<sup>g</sup>Rangely District Hospital, Colorado  
Wilson Memorial Hospital, Texas

<sup>h</sup>Calhoun General Hospital, Florida

<sup>i</sup>St. Luke General Hospital, Louisiana

<sup>j</sup>Churchill Regional Medical Center, Nevada  
Elko General Hospital, Nevada  
Mt. Grant General Hospital, Nevada  
Nye Regional Medical Center, Nevada  
Boone County Community Hospital, Nebraska

<sup>k</sup>LaHarpe Hospital Association, Illinois

<sup>l</sup>Corning Community Hospital, Arkansas

<sup>m</sup>Baxter Memorial Hospital, Kansas

<sup>n</sup>Grantees not extending grant funding for third year

<sup>o</sup>Methodist Hospital, South Dakota

<sup>p</sup>Putnam County Hospital, Indiana  
Helena Regional Medical Center, Arkansas  
Odessa Memorial Hospital, Washington



Hospital in Mitchell, South Dakota (not an RHCT grantee). In doing so, the hospital exceeded the 100-bed legislative limit and was no longer eligible to participate in the RHCT grants program.

Three hospitals opted independently to use their own funds to complete the projects originally funded by their 1989 RHCT grants in order to accept a 1991 RHCT grant award. The hospitals, Putnam County Hospital in Indiana, Helena Regional Medical Center in Arkansas, and Odessa Memorial Hospital in Washington, won \$50,000 grants for the first year of their 1991 RHCT grant projects and chose to accept their 1991 RHCT grant awards rather than continue with the third year of their 1989 RHCT grant awards. Their choice was driven by the legislative mandate that a hospital grant not exceed \$50,000 a year.

## **2. 1990 Grantees**

On September 15, 1990, HCFA awarded 212 grants to 211 hospitals. The majority of the hospitals awarded grants in FY 1990 remain active 18 months later (see Table I.2). As of March 31, 1992, 200 hospitals are still operating 201 grant projects. The continuing hospitals are listed in Appendix A.

Only one hospital, North Claiborne Hospital in Louisiana, has left the RHCT grant program during the past 6 months. The hospital closed in January 1992 because it lost both of its physicians and was unable to sustain its operations.

TABLE 1.2  
1990 GRANTEE STATUS

	Time Period				
	At Award 9/15/90	Month 6 3/31/91	Month 12 9/30/91	Month 18 3/31/92	Cumulative 9/15/90 - 3/31/92
Number of Grantees (Hospitals) at Start of Period	212 (211)	210 (209)	210 (209)	202 (201)	212 (211)
Number of Voluntary Terminations in Period	2 <sup>a</sup> (2)	0 (0)	4 <sup>b</sup> (4)	0	6 (6)
Number of HCFA Terminations in Period	0	0	0	0	0
Number of Hospitals Ceasing Operations and Terminated in Period	0	0	2 <sup>c</sup> (2)	1 <sup>e</sup> (1)	3 (3)
Number Completed in Period	0	0	2 <sup>d</sup> (2)	0	2 (2)
Number Remaining at End of Period	210 (209)	210 (209)	202 (201)	201 (200)	201 (200)
Other Changes:					
Ceased hospital operations but is still a grantee	0	0	0	0	0
Changed scope	0	0	0	0	0
Other	0	0	0	0	0

<sup>a</sup>Seymour Hospital, Texas  
Frio Hospital Association, Texas

<sup>b</sup>St. Anthony Hospital, Oregon  
Maude Norton Memorial City Hospital, Kansas  
Tyler County Hospital District, Texas  
Throckmorton Hospital, Texas

<sup>c</sup>Tri County Hospital, Michigan  
Dade County Memorial Hospital, Missouri

<sup>d</sup>Francis A. Bell Memorial Hospital, Michigan  
Tippah County Hospital, Mississippi

<sup>e</sup>North Claiborne Hospital, Louisiana

### 3. 1991 Grantees

On September 15, 1991, HCFA awarded 187 RHCT grants. As of January 1, 1992, 183 hospitals are still operating their grant projects (see Table I.3). The continuing hospitals are listed in Appendix A.

Only one hospital, Robersonville Medical Center in North Carolina, has left the program during the past 6 months. HCFA terminated the institution because it did not meet the conditions of participation for the RHCT grants program.

Thus far, only one hospital, Hardin County General Hospital in Illinois, has requested to change the scope of its original project. Hardin County General had originally proposed using its RHCT grant funds to expand its home health care laboratory services and to provide continuing education programs for the laboratory staff. However, changes at the hospital have increased the hospital's need for primary care physicians, and the hospital is thus redirecting its RHCT grant funds toward recruiting and relocating primary care physicians and purchasing diagnostic equipment for a visiting cardiologist.

One grantee ceased operations as an acute care hospital during the past 6 months but remains a RHCT grantee. The hospital, St. John Hospital in Kansas, had originally planned to use its RHCT grant funds to convert from an acute care hospital to a primary care hospital. However, the hospital could not afford to maintain operations and ceased providing inpatient care. The hospital is currently using RHCT grant funds to continue its transition to a rural health care clinic.

TABLE I.3  
1991 GRANTEE STATUS

	At Award 9/15/91	Month 3 1/1/92	Cumulative 1/1/92
Number of Grantees (Hospitals) at Start of Period	187 (187)	184 (184)	187 (187)
Number of Voluntary Terminations in Period	1 <sup>a</sup> (1)	0	1 (1)
Number of HCFA Terminations in Period	0	1 <sup>c</sup> (1)	1 (1)
Number of Hospitals Ceasing Operations and Terminated in Period	2 <sup>b</sup> (2)	0	2 (2)
Number Completed in Period	0	0	0
Number Remaining at End of Period	184 (184)	183 (183)	183 (183)
Other Changes:	0	0	0
Ceased hospital operations but is still a grantee	0	1 <sup>d</sup>	1
Changed scope	0	1 <sup>e</sup>	1
Other	0	0	0

<sup>a</sup>Bonner General Hospital, Idaho

<sup>b</sup>John MacDonald Hospital, Iowa  
Moshannon Valley Community Hospital, Pennsylvania

<sup>c</sup>Robersonville Medical Center, North Carolina

<sup>d</sup>St. John Hospital, Kansas

<sup>e</sup>Hardin County General Hospital, Illinois

## II. SELF-REPORTED PROGRESS OF 1989 GRANTEES

In the Omnibus Budget Reconciliation Act of 1987, Congress mandated that HCFA provide semi-annual progress reports on the RHCT grantees. A monitoring process was established to ensure that grant funds were spent in a manner consistent with project goals and in accordance with regulations. The process was also designed to inform both HCFA and Congress on how grant funds were allocated under the program, and on the progress of grantees toward implementing their projects. Thus, under the terms and conditions of the grant awards, grantees are required to report the amount of grant funds spent and the progress made on their projects every 6 months. The fifth report from grantees, which covered the period from October 1, 1991, through March 30, 1992, was due on April 17, 1992. Of the 145 grant projects (143 hospitals) still active during this reporting period, 127 returned their monitoring reports in time to be processed for this congressional report. The information presented in this chapter is based on the self-reported progress made by these 127 grantees.

Two and a half years after receiving their grants, the grantees continue to attribute the success of their projects principally to the availability of funds (in particular, funds received from the RHCT grant), and the demand for project services. They also continue to mention the same difficulties: recruiting and retaining personnel and financing the project. The bulk of the grant funds continue to be spent on personnel, contracts, and capital.

## **A. ACHIEVEMENTS**

The goal of the RHCT grants program is to help rural hospitals improve their financial viability and maintain or increase access to health care in rural areas. A measure of success is the extent to which the grantees recruit physicians, implement health care services that are used by residents, and complete other activities that improve the quality of available services (for example, by buying better equipment) or improve future financial viability (for example, by establishing a rural health network).

The following sections are based upon information provided in the fifth monitoring report. The 1989 grantees did not report as much detail as they have in the past. Hence, the figures reported here should be viewed as a minimum level of progress.

### **1. Service Implementation**

One goal of the RHCT grants program is to increase access to care among rural residents. Whether the grantees achieve this goal depends on whether they actually implemented or upgraded patient services, how long it took to implement the services, and, once implemented, whether the local residents used the services. Fifty-three of the 1989 grantees reported using grant funds to implement or enhance 79 patient services (see Table II.1). Over 60 percent of these services are outpatient services (49 projects), 11 percent are inpatient services (9 projects), 10 percent are transportation services (8 projects), and the remainder are well-patient/social services (13 projects). The outpatient services most frequently developed or enhanced were physician services (eight projects), home health and hospice services (seven

TABLE II.1

LENGTH OF TIME UNTIL PATIENT SERVICES WERE IMPLEMENTED OR UPGRADED: 1989 GRANTEES

Service	Number Implemented	Average Number of Months After Grant Award	Percent Implemented or Upgraded within (Cumulative Percentage):				
			6 Months After Grant Award	12 Months After Grant Award	18 Months After Grant Award	24 Months After Grant Award	30 Months After Grant Award
<b>Outpatient</b>	<b>49</b>	<b>19</b>	<b>20 %</b>	<b>31 %</b>	<b>39 %</b>	<b>51 %</b>	<b>100 %</b>
Physician services	8	21	13 %	25 %	25 %	50 %	100 %
Home health agency/hospice	7	17	43 %	43 %	43 %	43 %	100 %
Diagnostic services	7	17	29 %	29 %	43 %	43 %	100 %
Emergency services	6	16	33 %	33 %	50 %	67 %	100 %
Cardiac clinic	5	22	0 %	20 %	20 %	20 %	100 %
Physical therapy services	4	16	25 %	50 %	50 %	50 %	100 %
Rural health clinic	3	20	0 %	33 %	33 %	33 %	100 %
Pulmonary rehabilitation	2	11	50 %	50 %	50 %	100 %	100 %
Outpatient mental health services	2	18	0 %	50 %	50 %	100 %	100 %
Oncology chemotherapy clinic	2	26	0 %	0 %	0 %	50 %	100 %
Outpatient surgery	1	16	0 %	0 %	100 %	100 %	100 %
Occupational therapy	1	28	0 %	0 %	0 %	0 %	100 %
Mobile health clinic	1	16	0 %	0 %	100 %	100 %	100 %
<b>Inpatient</b>	<b>9</b>	<b>14</b>	<b>33 %</b>	<b>56 %</b>	<b>67 %</b>	<b>67 %</b>	<b>100 %</b>
Mental health inpatient services	7	14	29 %	57 %	72 %	72 %	100 %
Nursing home beds	1	25	0 %	0 %	0 %	0 %	100 %
Ventilator dependent unit	1	0	100 %	100 %	100 %	100 %	100 %

TABLE II.1 (continued)

Service	Number Implemented	Average Number of Months After Grant Award	Percent Implemented or Upgraded within (Cumulative Percentage):				
			6 Months After Grant Award	12 Months After Grant Award	18 Months After Grant Award	24 Months After Grant Award	30 Months After Grant Award
<b>Transportation</b>	<b>8</b>	<b>18</b>	<b>25 %</b>	<b>38 %</b>	<b>50 %</b>	<b>50 %</b>	<b>100 %</b>
Emergency medical	5	23	20 %	20 %	20 %	20 %	100 %
Non-emergency medical	3	11	33 %	67 %	100 %	100 %	100 %
<b>Well Patient</b>	<b>10</b>	<b>19</b>	<b>20 %</b>	<b>30 %</b>	<b>40 %</b>	<b>50 %</b>	<b>100 %</b>
Patient/community education	5	19	20 %	20 %	20 %	20 %	100 %
Adult day care	2	19	0 %	50 %	50 %	50 %	100 %
Social services	2	11	50 %	50 %	100 %	100 %	100 %
Wellness/fitness programs	1	21	0 %	0 %	0 %	100 %	100 %
<b>Other Patient Services</b>	<b>3</b>	<b>24</b>	<b>33 %</b>	<b>33 %</b>	<b>33 %</b>	<b>33 %</b>	<b>100 %</b>
<b>Total Number of Patient Services</b>	<b>79</b>	<b>18</b>	<b>23 %</b>	<b>35 %</b>	<b>44 %</b>	<b>54 %</b>	<b>100 %</b>

SOURCE: Fifth 1989 Grantee Monitoring Report.

NOTE: A grantee can implement more than one patient service. These 79 services were implemented by 53 grantees.



projects), and diagnostic services (seven projects). Almost all of the inpatient projects (seven of nine) developed inpatient mental health services, while the majority of the transportation projects (five out of eight) enhanced emergency transportation services.

**a. Timeframe for Implementation**

Grantees took less time to implement or upgrade inpatient service projects than outpatient, transportation, or well-patient and social service projects. On average, inpatient service projects began serving patients 14 months after the grants were awarded in September 1989, while the outpatient, transportation, and well-patient projects began serving patients approximately 19 months after award--5 months later (see Table II.1). This difference is due to the large proportion of outpatient and transportation projects that took over 2 years to implement. While 51 percent of the outpatient projects and 50 percent of the transportation projects were implemented within 2 years, this implies that almost half of the outpatient projects (49 percent) and half of the transportation projects (50 percent) began providing care 2 years after the 1989 grantees received their award. In contrast, 56 percent of the inpatient projects were implemented within 1 year of receiving the award.

The shorter lag time between grant awards and the implementation of inpatient services does not imply that inpatient projects can be implemented more quickly. The reason for the observed difference in the speed at which these projects were implemented is that many grantees are implementing outpatient or transportation projects that they identified in the planning phase of the project in the first year. In fact, 79 percent of the outpatient, transportation, and wellness and social service projects were implemented with planning or

planning and implementation grants. Hence, these project services were not even considered until the 1989 grantees were well into their grant period. In contrast, 50 percent of the inpatient services were already planned before the hospitals were awarded their grants.

#### **b. Utilization Rates**

Implementing service projects is important for increasing access to care. However, if patients do not use the services, then making the services available does not increase access to care, nor will it improve the financial viability of the hospitals.

The utilization rates among the service projects varied widely. The grantees provided us with one of two measures of utilization: average number of patients served per month or average number of patient visits.<sup>1</sup> The utilization rates for the more generalized outpatient services, such as the rural health clinics, mobile health clinics, emergency services and diagnostic services, are higher than those for the specialty services, such as oncology chemotherapy, outpatient mental health services, and occupational therapy (see Table II.2). The same is true among the inpatient services--the lone nursing-home project has been serving 59 patients per month since the day it opened, in contrast to the average of 11 patients per month served in the 7 inpatient mental health facilities and the 6 patients per month in the lone Ventilator Dependent Unit. This does not imply that specialty services are not beneficial to the grantee hospitals or their communities. But it does suggest that due to the low volume

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<sup>1</sup>In some cases, the grantees provided both patients served and number of visits. In these cases, we report the number of patient visits.

TABLE II.2  
AVERAGE NUMBER OF PATIENTS SERVED PER MONTH  
AND THE NUMBER OF PATIENT VISITS PER MONTH:  
1989 GRANTEES

Service	Average Number of Patients Served Per Month	Average Number of Patient Visits Per Month
<b>Outpatient</b>		
Physician services	10	320
Home health agency/hospice	65	83
Diagnostic services	796	--
Emergency services	317	515
Cardiac clinic	102	59
Physical therapy services	19	355
Rural health clinic	305	230
Pulmonary rehabilitation	234	113
Outpatient mental health services	72	15
Oncology chemotherapy clinic	12	45
Outpatient surgery	25	--
Occupational therapy	--	14
Mobile health clinic	100	--
<b>Inpatient</b>		
Mental health inpatient services	11	--
Nursing home beds	59	--
Ventilator dependent unit	6	--
<b>Transportation</b>		
Emergency medical	20	--
Non-emergency medical	77	--

TABLE II.2 (continued)

Service	Average Number of Patients Served Per Month	Average Number of Patient Visits Per Month
<b>Well Patient</b>		
Patient/community education	223	--
Adult day care	--	32
Social services	225	7
Wellness/fitness programs	3,331	--
<b>Other Patient Services</b>	27	75
<b>Total Number of Patient Services</b>	13,499 <sup>a</sup>	5,280 <sup>b</sup>

SOURCE: Fifth 1989 Grantee Monitoring Report.

NOTE: Some grantees only track the number of patients served, while others only track the number of visits. If visits were available, the number of visits is reported; otherwise, the number of patients being served is reported.

<sup>a</sup>Defined as average number of patients served multiplied by the number of grantees providing the service summed across all services.

<sup>b</sup>Defined as average number of visits multiplied by the number of grantees providing the service, summed across all services.

of use, these more specialized projects may have a smaller impact on access to care and on the hospitals' financial viability.<sup>2</sup>

Of the 79 services implemented, 54 reported number of patients served. Summing across these 54 services, we find that 13,499 patients per month now receive services at their local hospital who otherwise would have had to travel for the service or done without. The highest volumes of services being rendered are diagnostic and emergency services, both of which have high average utilization and were implemented by six or more hospitals.

### **c. Change in Institutional Type or Size**

In addition to increasing local access to care, a key goal of the RHCT grants program is to help grantees become financially viable institutions. To become financially viable, acute-care hospitals that are underutilized must downsize the number of acute-care beds and use the space for other services or, alternatively, close acute-care services altogether and convert the space to primary or long-term care services. After 2 years of participation in the grant program, 25 of the active grantees (18 percent) reduced the number of licensed beds or transitioned into another type of institution.<sup>3</sup> Eighteen grantees have increased the number of licensed beds during this period, representing 13 percent of the active grantees. Thus, 69 percent have not changed the number of licensed beds during the first 2 years.

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<sup>2</sup>This is not necessarily true. If the low-volume service complements other hospital services, then having the service available may have a large impact on finances.

<sup>3</sup>This is based on the 142 grantees that submitted both a first and a fourth background report.

Examining the 53 grantees that reported implementing 79 services, we find that 38 percent of the projects implemented by hospitals that downsized during the period were transportation or well-patient projects, whereas only 27 percent of the projects implemented overall were transportation or well-patient hospitals. Sixty-seven percent of the projects implemented by those that retained the same number of licensed beds during this period were outpatient service projects (see Table II.3). Grantees that expanded their acute-care bed capacity were more likely to implement inpatient service projects than the other grantees.

The tendency for downsizing hospitals to implement transportation and well-patient projects is likely due to their desire to remain visible in the community at this critical juncture. Uninformed citizens may believe that downsizing signals poor quality services or is a sign that the hospital is about to close. Wellness and transportation projects are very visible throughout the community and are thus likely to help maintain the hospital's image as a viable facility rather than a failing facility.

## **2. Recruiting Physicians**

A second method for enhancing access to care and maintaining the hospital's financial viability is to recruit physicians to the area. Without physicians, patients cannot be admitted to an acute-care facility, and the facility cannot remain viable without patients.

The grantees whose goal was to recruit and retain physicians have mostly done so; however, their recruiting success has barely increased their staff size. During the first 2 years of the program, a total of 104 physicians have been recruited by the 53 grantees that devoted grant funding to physician recruitment, for an average of just under 2 physicians per grantee.

TABLE II.3

NEW SERVICES IMPLEMENTED OR UPGRADED WITH GRANT FUNDS:  
1989 GRANTEES' CHANGES IN LICENSED ACUTE-CARE BEDS

	Inpatient Services	Outpatient Services	Transportation and Well-Patient Services	Total Patient Services
Reduction in Licensed Acute-Care Beds	2 (13%)	8 (50%)	6 (38%)	16
No Change in Licensed Acute-Care Beds	5 (10%)	35 (67%)	12 (23%)	52
Increase in Licensed Acute-Care Beds	2 (18%)	6 (55%)	3 (27%)	11
Total Number (100%)	9 (11%)	49 (62%)	21 (27%)	79

NOTE: Row percentages are in parentheses.

Despite this success, 75 percent of these grantees are still recruiting physicians, and 28 percent are still recruiting three or more physicians (see Table II.4). This high-level of ongoing recruiting effort is necessitated by the loss of physicians among the grantees in the period: 70 percent of the 1989 grantees that devoted their grant funds to recruiting physicians have lost at least one physician during the past 2 years, and 17 percent have lost three or more physicians. Thus, the average net gain in physicians is only .45 physicians per grantee.

Using grant funds for recruiting purposes is no more effective than using other funds to recruit physicians; the average net increase in physicians among grantees that used their grant funds for physician recruitment is similar to the net increase of those that used other funds to recruit physicians--.45 physicians versus .49 physicians, respectively (see Table II.4). Hospitals whose projects were not oriented toward recruiting physicians recruited an average of two physicians, the same number as those whose project goal was physician recruitment.

The fact that the recruitment-oriented and non-recruitment-oriented projects recruited a similar number of physicians reflects the importance of physician recruits among rural hospitals. A hospital cannot survive without physicians; hence hospitals will find the resources necessary to recruit physicians--even if it means cutting other items from the budget. Hence, it is not surprising that the availability of grant funding does not necessarily affect the number of physicians recruited; however, grantees that received grant funds for recruiting were probably more likely to be able to maintain other services.



TABLE II.4  
PHYSICIAN RECRUITING AND RETENTION OVER 2 YEARS:  
1989 GRANTEES

	Physician Recruitment/Retention Is a Project Goal	Physician Recruitment/Retention Is not a Project Goal
Number of Grantees	53	67
<b>Recruitment</b>		
Average Net Physician Additions	.45	.49
Percent of grantees not recruiting physicians	25 %	34 %
Percent of grantees recruiting one physician	26 %	12 %
Percent of grantees recruiting two physicians	21 %	13 %
Percent of grantees recruiting three or more physicians	28 %	41 %
<b>Retention</b>		
Percent of grantees losing no physicians	30 %	38 %
Percent of grantees losing one physician	36 %	35 %
Percent of grantees losing two physicians	17 %	7 %
Percent of grantees losing three or more physicians	17 %	20 %

SOURCE: First, Second, Third, and Fourth Monitoring Report; 120 grantees reporting.

### **3. Other Grant Activities Completed**

The 1989 grantees have completed a number of other activities in their grant projects. Among the active 1989 grantees, 71 percent have completed planning activities, and 85 percent have completed equipment-purchase activities (see Table II.5). These high completion rates are expected; the grantees have reported being on schedule with these activities throughout their 30 months in the program. Grantees have also overcome construction delays--the majority of the grantees undertaking construction activities reported falling behind schedule early in the project, but now 80 percent report having completed their construction.

The grantees report relatively low completion rates for two other activities--training and staff development (38 percent complete) and the creation of a rural health network (54 percent complete). The low completion rates for training and staff development are expected; these activities are generally ongoing at the hospital, and in most instances the grant-supported training will continue even after the grant ends. The low completion rates for establishing a rural health network reflect the extreme difficulty of establishing cooperative efforts with institutions that are volatile.

### **B. THE OPERATIONAL SUCCESSES AND DIFFICULTIES OF THE 1989 GRANTEES**

One goal of the evaluation of the RHCT grant program is to determine how the grantees achieve their success. Other rural hospitals will be able to learn from and replicate the grantees' projects if they know what factors were important for success, what problems were encountered and how these problems were surmounted.

TABLE II.5  
OTHER GRANT ACTIVITIES COMPLETED AFTER 30 MONTHS:  
1989 GRANTEES

Activity	Number Pursuing This Activity	Number (and Percent) Completing This Activity
Planning or Market Analysis	75	53 (71 %)
Construction or Renovation	57	46 (80 %)
Equipment Purchase	106	91 (86 %)
Training or Staff Development	101	38 (38 %)
Establishing a Rural Health Network	46	25 (54 %)

NOTE: This table is based on all progress forms ever received from the 127 active and reporting grantees.

## 1. Successes

In general, the 1989 grantees cited very few factors contributing to the success of their project during the past 6 months. The grant projects have been operating for 30 months and this is the fifth progress report they have completed. At this late stage the grantees may not feel they have anything new to say, and thus did not cite many success factors.

The single success factor cited by the majority of the grantees is the availability of funds. Over 62 percent of the 1989 grantees cited the availability of funds--in particular, the RHCT grant funds--as the reason for their success. Some of the grantees that cited the availability of grant funds as the key factor urged that the RHCT grants program be extended to give other rural hospitals the same opportunity; they were clearly lobbying for the extension of the program. Other grantees explained that their proposed project took longer than expected to become financially viable, and without the grant funds, their hospitals could not have maintained the projects long enough to reach their full potential. Still other grantees documented the accomplishments that have been made with the funds and explained that none of them would have been possible without Federal assistance.

Another reason for the success of the grant projects is that they are meeting a real need in their community--and are thus realizing higher-than-anticipated utilization rates. A new 60-bed nursing home that was developed with assistance from the grant funds has served 59 patients since the day the facility opened--a level of utilization that the hospital administration expected would take a few months to obtain. A cardiac rehabilitation facility has turned away patients because it cannot meet the demand for the service; the project is

now trying to find new space within the hospital to expand its service in response to the community's demand. A program that provides wellness instruction and health screening opportunities for senior citizens reports a 154-percent increase in enrollment over the past 6 months, and now has over 3,000 elderly residents enrolled and taking part in the program. These high utilization levels have allowed the projects to become self-supporting before the end of the grant period.

## **2. Problems**

The 1989 grantees reported only a few problems that have impeded their grant projects--consistent with the solid progress that they have reported. However, two problems that continue to be cited are professional recruitment and retention problems (cited by 24 percent of the grantees) and funding difficulties (cited by 18 percent of the grantees).

Recruiting and retaining health care professionals continues to be a major stumbling block for the grantees. Their inability to attract family practice physicians, registered nurses and physical therapists has frustrated many of the grantees. One hospital reports that it is reaching a critical juncture--its new building is nearly completed, and the hospital has yet to recruit a physician to practice in it. The hospitals attribute their inability to attract health care professionals to the lack of available personnel, and most plan to keep pursuing the same recruitment strategies in the hopes that eventually they will be successful.

In addition to recruiting health care providers, retaining health care administrators also remains a problem. A few grantees report that their program coordinators have left their positions over the past 6 months, slightly disrupting the progress of the projects. However,

the grantees are not reporting that the administrative turnover is *halting* the progress of the projects, as they did when they were just initiating their projects. The projects of the 1989 grantees appear to have matured to the point at which they can weather administrative turnover.

Difficulties with nongrant project funding have also delayed the implementation of some projects. For example, one hospital noted that the poor economic climate has made it difficult to reach its fund-raising goals; and others noted that budgetary constraints at the local government level have reduced anticipated allocations to the hospital.

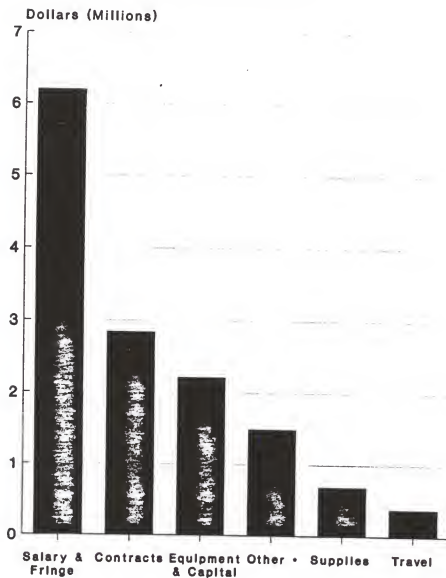
### C. EXPENDITURES

During the first 2 years of the grant period, HCFA awarded \$15,412,515 in RHCT grants to the 1989 grantees. Because the law that extended the grant period from a maximum of 2 years to 3 years did not take effect until after the 1989 awards were made, the 1989 grantees received 2-year awards. However, HCFA agreed to cover project costs up to a maximum of \$50,000 per hospital to hospitals that requested third-year funding. One hundred forty-seven hospitals (149 grant projects) requested third-year funding, increasing the obligated total to \$22,762,515.

Thirty months into their grant projects, the reporting 1989 grantees with 3-year awards had spent \$13,795,415. Figure II.1 shows how the hospitals allocated their grant funds. The expense distribution, which is relatively similar to the distribution at 2 years, shows that expenses fall primarily into three categories:

- **Personnel (includes fringe):** \$6,194,239 (45 percent)

**FIGURE II.1**  
**TOTAL EXPENDITURES BY CATEGORY**  
**IN THE FIRST 30 MONTHS:**  
**1989 GRANTEES**



• NOTE: 'Other' includes expenditures like advertising, telephone and photocopying

- **Contracts:** \$2,839,562 (21 percent)
- **Capital:** \$2,210,833 (16 percent)

Thirty months into their grant projects, 77 of the 127 reporting 1989 grantees (61 percent) had spent more than three-quarters of their awards, and 31 (24 percent) had spent between 51 and 75 percent of their awards (see Figure II.2). Another 19 grantees (15 percent) spent less than half of their awards.

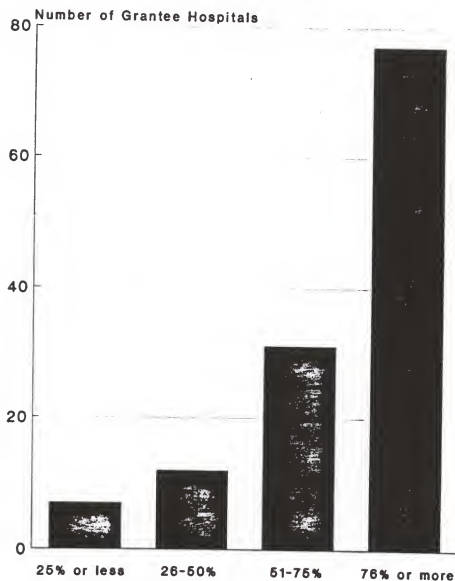
Not surprisingly, the goals of the project affected how the grant funds were allocated. For example, projects that depended on staffing availability usually had higher salary expenses. Thus, hospitals that established new health care services, wellness and prevention services, and, in particular, rural health networks spent a greater share of their grant funds on salaries. Higher personnel costs were also associated with recruitment and equipment-purchasing activities.

Hospitals that implemented recruitment, equipment purchases, management improvements, planning and marketing, and prevention and wellness projects also reported spending a larger proportion of their grant funds on travel. These activities are those for which some traveling would be necessary.

Capital expenses were higher among hospitals that implemented equipment purchases, management improvements, and planning and marketing. Finally, hospitals that implemented equipment purchases, planning and marketing, and prevention and wellness projects spent a greater share of their grant funds on supplies.



**FIGURE II.2**  
**PERCENT OF TOTAL FUNDING SPENT**  
**IN THE FIRST 30 MONTHS:**  
**1989 GRANTEES**



### III. SELF-REPORTED PROGRESS OF 1990 AND 1991 GRANTEES

#### A. PROGRESS OF 1990 GRANTEES

Of the 211 hospitals initially awarded RHCT grants in 1990, 201 spent grant funds during the last 6 months.<sup>1</sup> Each hospital has one grant project, with the exception of one hospital that has two. Of the 201 grantees, 169 (84 percent) submitted monitoring reports in time to be included in this report.

##### 1. Achievements

###### a. Progress Relative to Schedule

The 1990 grantees continue to make steady progress on their grant projects. Three percent of the reporting hospitals have completed all of their project activities, 53 percent were ahead of or on schedule, and 44 percent were a month behind schedule (see Table III.1). This distribution remains unchanged from what the grantees reported 6 months ago. However, the 1990 grantees were slightly ahead of the 1989 grantees at the same point in time. After 18 months, none of the 1989 grantees reported having completed all of their grant activities, and 50 percent reported being a month behind schedule on at least 1 activity (Cheh, Condon, Nagatoshi, and Wooldridge, 1991).

The 1990 grantees continue to be most successful at completing activities such as equipment purchases, planning and marketing analysis, and the recruitment of health care

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<sup>1</sup>One of these hospitals, North Claiborne in Louisiana, closed down after having spent some RHCT grant funding during this reporting period. However, the hospital completed its monitoring report, and the information is included in this report.

TABLE III.1  
DISTRIBUTION OF THE PROGRESS OF PROJECTS BY OBJECTIVE:  
1990 GRANTEES\*

Project Objective	Total Number	Ahead of Schedule	On Schedule	Behind Schedule by More than One Month	Completed
Planning or Market Analysis	82	2 %	44 %	6 %	48 %
Construction or Renovation	50	4 %	40 %	30 %	26 %
Equipment Purchase	120	2 %	34 %	15 %	49 %
Recruiting	135	--	39 %	25 %	36 %
Training or Staff Development	83	--	72 %	15 %	13 %
Education, Prevention, or Wellness Programs	78	1 %	85 %	9 %	5 %
Inpatient or Hospice Service	13	--	62 %	23 %	15 %
Outpatient Service	59	5 %	70 %	19 %	7 %
Clinic	38	3 %	47 %	21 %	29 %
Emergency Medical Services	14	21 %	64 %	7 %	7 %
Swing Beds	4	--	50 %	50 %	--
Other Health Service	20	--	60 %	25 %	15 %
Rural Health Network	59	--	56 %	24 %	20 %
Other	21	--	52 %	43 %	5 %
Total	169	--	53 %	44 %	3 %

NOTE: Totals may not add to 100 percent due to rounding error. Only grantees who were still active at the end of 18 months are included.

Progress is defined by the project's most-delayed activity. For example, a project that is on schedule in only one activity and ahead of schedule in all the rest is defined to be on schedule.

\*One hospital did not report timeliness.

professionals. Consistent with previous reports submitted by the 1989 and 1990 grantees, hospitals that have introduced new services have adhered largely to schedule. For example, 86 percent of the prevention and wellness projects, 85 percent of the emergency medical service projects, and 75 percent of the outpatient service projects were either ahead of or on schedule.

Consistent with the previous reports, hospitals have fallen behind schedule on activities over which they have incomplete control, including construction and recruitment.<sup>2</sup> Because recruitment is the single most frequent activity, fully 20 percent of all grantees are behind schedule due to recruitment problems, although 29 percent of all grantees have completed this activity. During the past 6 months, the 1990 grantees made noticeable progress in their emergency service projects. Six months ago, half of the grantees that have implemented emergency service projects were behind schedule; currently, only seven percent are behind schedule (Cheh, Giggie, Nagatoshi, and Wooldridge, 1992).

Primarily external constraints have affected the hospitals' success in keeping to their project schedules. Hospitals behind schedule were more likely than the others to cite the lack of cross-organizational support, recruiting and retention difficulties, regulatory constraints, and the lack of funding as problems (see Table III.2).

Contrary to expectations, the size and administrative and financial stability of a hospital is inversely related to its adherence to schedule. Hospitals behind schedule were more likely

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<sup>2</sup>A large proportion of swing bed and "other" projects are also reportedly behind schedule. Many of the "other" projects behind schedule are also those which the hospitals do not have full control over. Only four hospitals have swing-bed projects.

TABLE III.2

PROBLEMS WITH GRANT PROJECTS LISTED BY PROJECTS  
THAT ARE ON OR BEHIND SCHEDULE: 1990 GRANTEES

Type of Problem	Completed or On Schedule (N=94)	Behind Schedule (N=75)
Lack of Cross-Organizational Support	4 %	20 %
Recruiting and Retention	26 %	40 %
Lack of Funding	17 %	29 %
Regulatory Constraints	7 %	19 %
Lack of Physician Support	4 %	11 %
Administrative or Operational Difficulties	30 %	44 %
Staff Resistance	5 %	0 %
Other Problems	6 %	8 %
Lack of Personnel	3 %	4 %
Lack of Demand	5 %	5 %
Lack of Community Support	2 %	3 %

to be large (in excess of 75 licensed beds), not to have hired a new administrator in the past 6 months, and to have had a positive operating margin in the first year of their grants (see Table III.3). This suggests that at larger hospitals--where the grant project may be one of many activities--there may be a higher probability for the grant project to fall behind schedule. In addition, these larger institutions may be more confident about reporting these slippages, as they have experienced them on other projects and know they can be overcome.

## **2. Operational Successes and Difficulties**

### **a. Successes**

Hospitals have the following explanations for the success of their projects:

- The availability of financial resources (cited by 60 percent)
- The dedication of the hospital staff (cited by 44 percent)
- Cross-organizational support (cited by 33 percent)
- Community support (cited by 29 percent)

Sixty percent of the hospitals cited the *availability of financial resources* as a reason for the project's success; nearly all of them were referring to their RHCT grant funds. Many of these hospitals indicated that they would not have been able to implement their projects without the grant. A hospital that is using its grant funds to develop programs in cardiac rehabilitation and patient education attributed its continuing existence to the grant. Another hospital that implemented a skilled nursing facility reported having a positive bottom line for the first time in 5 years.

TABLE III.3

THE CHARACTERISTICS OF HOSPITALS BEHIND SCHEDULE AFTER 18 MONTHS:  
1990 GRANTEES

	Percent Completed or On Schedule	Percent Behind Schedule	Total Number of Projects
Number of Licensed Beds			
Less than 25	59 %	41 %	29
26 - 50	55 %	45 %	83
51 - 75	59 %	41 %	27
76 or more	46 %	54 %	26
Change in Administration			
Change in past 6 months	65 %	35 %	23
No change in past 6 months	54 %	46 %	146
Financial Problems			
Negative operating margin in first year of grant	58 %	42 %	98
Positive operating margin in first year of grant	52 %	48 %	63

NOTE: Behind schedule is defined as behind schedule by 1 month or more in any grant activity.

Other hospitals cited other benefits of the grant award. According to one hospital, the very fact that the Federal Government considered its project worthy of funding gave it credibility and reduced resistance. In other instances, the grant improved staff morale or motivated staff to look for other external sources of funding.

The second most frequently cited reason for a project's success was the *support and dedication of the hospital staff*. Many hospitals indicated that the cooperation of their staff was the key ingredient in their success. Other hospitals attributed the success of their projects to the initiative and leadership of a particular individual. For example, the efforts of one project coordinator will make it possible for a hospital to provide on-site child care for its employees. The project coordinator found an alternative facility after the hospital's Board of Trustees elected not to proceed with constructing a child care facility until all the funding was secured.

One-third of the hospitals cited the *support they received from other organizations* as a reason for their success. One energetic grantee, assisted by a larger hospital, is implementing a project to improve hospital management and to develop and implement a strategic plan for the care of the area's elderly. Among the services it is considering are intermediate and skilled nursing care. With the support of a second large hospital, the grantee persuaded the West Virginia State legislature to exempt it from a moratorium on the construction of long-term care beds. Under this special law, the hospital will be able to apply for a certificate-of-need for up to 60 long-term care beds. While maintaining its working relationship with the first hospital, the grantee has signed an affiliation agreement with the second hospital.



The support of other organizations has in some instances helped create community interest in the project. One of the Texas hospitals is working with the Texas Tech Health Science Center to develop a two-way telecommunications program. This project has generated interest and enthusiasm among the hospital and medical staff, and in the community.

Another frequently mentioned reason for the success of the projects is *community support*. Some grantees rely on volunteers to staff the projects. For example, one hospital has trained 15 volunteer drivers for its nonemergency medical transportation service for the elderly. Another hospital was supported by the aggressive efforts of its community leaders at seeking funds to build a clinic, which in turn is expected to attract another physician to the area.

#### **b. Difficulties**

The 1990 grantees mentioned the following difficulties most often:

- Operational or administrative problems with projects (cited by 36 percent)
- Problems with recruiting or retaining staff (cited by 33 percent)
- The lack of financial resources (cited by 23 percent)

The difficulty mentioned most frequently by the 1990 grantees pertained to *operational and administrative* problems. These problems among the hospitals varied. Some grantees have found it difficult to develop a schedule to support the most efficient use of program staff. One hospital experienced a delay because of a 2-week strike by its nonprofessional staff. In other cases, the difficulties were due to the success of the project. The hospital that expanded its outpatient orthopedic clinic reported that the demand for service has created space problems.

The demand for another hospital's nonemergency transportation services has strained the program's resources.

Some hospitals reported difficulties with the acquisition of new skills, while others experienced difficulties in the face of unplanned events. A Kansas hospital that is consolidating its administrative services with the area's physician clinic cited both difficulties. As soon as its staff completed training in new accounting software, the Resource-Based Relative Value Scale payment for physicians was implemented, forcing the staff to undergo more training. Finally, a hospital in Colorado was forced to halt its mobile clinic project when the clinic vehicle was severely damaged in a collision with a cow. The hospital decided to sell the vehicle and establish clinics at the sites the mobile clinic was visiting.

One-third of the hospitals reported *staff recruitment and retention difficulties*--most of which was with physicians. One hospital successfully recruited two young family practitioners only to lose both of them within a year because of other opportunities and personality differences. The hospital is again trying to recruit a physician, this time someone older who may be more settled and likely to stay.

The third most frequently cited difficulty is the *lack of funding*, often forcing a hospital to scale back its project or creating project delays. Budget constraints have forced one of the hospitals to delay filling its vacant patient-educator position. Other hospitals mentioned the lack of or a reduction in government funding. A California hospital reported that its cardiac rehabilitation program was being hindered because MediCal did not cover the service. The hospital had originally projected that 80 percent of the patients would be covered by Medicare,

but the young elderly population (under age 65) had a higher demand for rehabilitation services projected. Many of these patients are covered by MediCal, and as a result, the cardiac rehabilitation program is providing a lot more charity care than it budgeted. Another hospital attributed reductions in reimbursement to the reluctance of specialists to visit its outpatient clinic as often as before. As a result of the cutback, the physicians are encouraging patients to travel to their offices instead of seeing them at the outpatient clinic.

### 3. Grant Expenditures

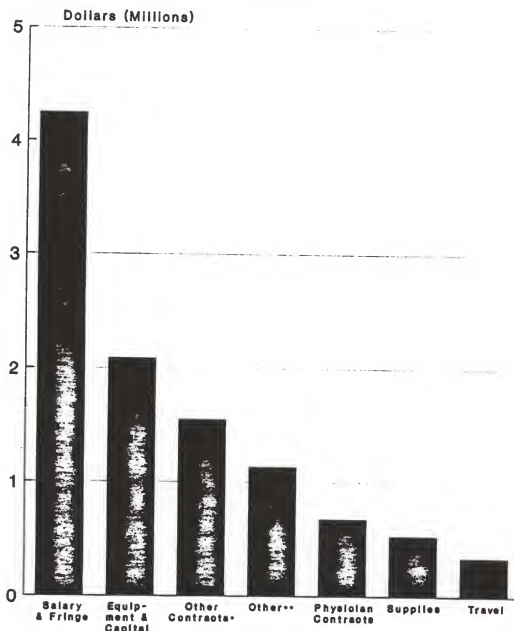
HCFA awarded \$18,034,375 to the 1990 grantees in the first 2 years--\$9,273,003 for the first year, and \$8,761,372 for the second year. The 171 reporting 1990 grantees spent \$10,544,084 during the first 18 months of their projects.

The grantees spent a majority (75 percent) of their grant funds on:

- **Personnel (including fringe):** \$4,245,234 (40 percent)
- **Equipment and capital:** \$2,088,308 (20 percent)
- **Nonphysician contracts:** \$1,547,853 (15 percent)

This expenditure distribution (shown in Figure III.1) changed only slightly since 6 months ago, when the 1990 grantees spent slightly less for personnel (37 percent) and slightly more on capital and nonphysician contracts (22 and 18 percent, respectively). Compared with the 1989 grantees 18 months into their projects, the 1990 grantees spent slightly less on personnel and contracts.

**FIGURE III.1**  
**TOTAL EXPENDITURES BY CATEGORY**  
**IN THE FIRST 18 MONTHS:**  
**1990 GRANTEES**



• NOTE: "Other Contracts" includes all non-physician contracts like building and management.

\*\* NOTE: "Other" includes expenditures like advertising, telephone and photocopying.

Halfway into the second year of their grant projects, 142 of the 171 reporting hospitals (83 percent) spent over half of their 2-year awards, with 72 (42 percent) having spent more than 75 percent (see Figure III.2). Another 20 (12 percent) spent between 26 and 50 percent of their awards, and only 9 (5 percent) spent less than a quarter of their awards during the first 18 months.

These numbers are quite consistent with those reported by the 1989 grantees at the same point in time. For example, 86 percent of the 1989 grantees had spent more than half of their 2-year awards, with 40 percent spending more than 75 percent of their awards. Similarly, 3 percent of the 1989 grantees spent less than 26 percent of their awards.

With the exception of the grantees that spent more than three-quarters of their 2-year grant funds, the level of spending does not appear to have affected the degree to which the grantees were able to maintain their schedules. As shown in Table III.4, 50 to 60 percent of the grantees that spent less than 75 percent of their awards were behind schedule. Those that spent more than 75 percent of their awards were less likely to be behind schedule. This pattern is quite different from the pattern found among the 1989 grantees 18 months into their projects. One reason for this difference is the types of projects that are behind schedule. The 1989 grantees had more construction projects that were behind schedule--and construction projects require more "up front" expenditures than other types of projects.

As might be expected, project activities influenced how the grantees allocated their funds. Service, planning, and recruitment projects have devoted a greater share of grant funds to personnel costs. In contrast, construction projects have devoted a greater proportion of funds

**FIGURE III.2**  
**PERCENT OF 2-YEAR FUNDING SPENT**  
**IN THE FIRST 18 MONTHS:**  
**1990 GRANTEES**

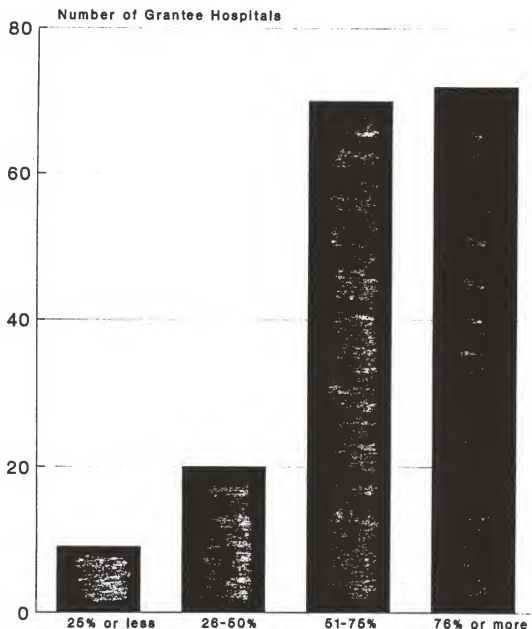


TABLE III.4

PERCENTAGE OF GRANT FUNDS SPENT BY THE PROGRESS OF PROJECTS: 1990 GRANTEES\*

Percent of 2-Year Grant Funds Spent After 18 Months	Total Number	Ahead of Schedule	On Schedule	Behind Schedule by More Than 1 Month	Completed
25 percent or less	8 <sup>b</sup>	0 %	50 %	50 %	0 %
26 - 50 percent	20	0 %	35 %	60 %	5 %
51 - 75 percent <sup>c</sup>	69	0 %	41 %	57 %	3 %
Greater than 75 percent	72	0 %	69 %	28 %	3 %
Total Number	169	0 %	53 %	44 %	3 %

NOTE: Totals may not add to 100 percent due to rounding error.

\*Project timeliness is defined by the project's most delayed activity. For example, a project that is on schedule in only one activity and ahead of schedule on all the rest is defined as on schedule.

<sup>b</sup>One grantee reported spending 8% of its total grant funds but did not report on project timeliness.<sup>c</sup>One grantee reported spending 48% of its total grant funds but did not report on project timeliness.

to equipment purchases and nonphysician contracts. Expenditures on equipment have also been greater among equipment-purchasing projects; nonphysician contract expenses have been greater among management improvement projects. Hospitals whose projects encompassed a significant information dissemination component, such as recruitment and prevention and wellness services, have devoted a greater share of their funding to supplies. Finally, travel costs are greater among projects in which rural health networks and hospital management improvements have been implemented.

#### **4. Project Modifications**

A few of the 1990 grantees have modified their projects due to changes in circumstances. Four hospitals have dropped components of their projects: one hospital dropped a home health care service because it was experiencing recruitment difficulties; another was forced to downsize and concluded that it could not maintain a medical transportation system; the third dropped its plans for a Rural Health Clinic when its survey showed that it would be detrimental to the physicians; and the other hospital dropped its plans for a senior advocacy program after discovering that the seniors' advocacy needs were non-health-related. In one case, a hospital's success at providing basic home health care services forced it to scale back its project so that it could provide services to more patients.

#### **B. START-UP OF THE 1991 GRANTEES**

HCFA awarded 187 RHCT grants to 187 hospitals in FY 1991. Of the 187 hospitals awarded RHCT grants in FY 1991, one withdrew from the program voluntarily before using



the grant funds, two had ceased operations and were discontinued from the program before they could use the grant funds, and one was discontinued from the program in the first 3-month reporting period for not meeting eligibility requirements. Information for this chapter comes from monitoring reports compiled by the 183 1991 grantee hospitals for their first 3 project months.<sup>3</sup> All but one of the hospitals completed monitoring reports in time to be processed for this congressional report.<sup>4</sup>

All of the hospitals started their RHCT grant projects on schedule, and the majority of the 1991 grantees have maintained their schedule. Even after only 3 months, a few grantees have already completed core project activities, such as hiring personnel (an activity completed by 20 hospitals) and purchasing equipment (an activity completed by 10 hospitals). However, close to one-third (58) of the hospitals are having start-up problems--pushing them behind schedule by more than 1 month on at least 1 core project activity. Thus, to supplement the information in the monitoring reports, we interviewed 20 of the hospitals by telephone that reported difficulties starting their projects to obtain more detailed information about the causes of their start-up problems.

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<sup>3</sup>The monitoring process for the 1991 grantees is the same as the process used by the 1989 and 1990 grantees, except that the reporting period differs slightly. The first monitoring report by the 1991 grantees covers the first 3 months of project activity, and subsequent monitoring reports will cover 6 months of project activity. The first monitoring report by the 1989 and 1990 grantees covered the first 6 months of project activity, and subsequent monitoring reports covered 6 months of project activity.

<sup>4</sup>Monitoring reports were due in early February 1992.

## **1. Project Activities on Schedule**

After 3 months, the 1991 grantees made progress primarily on activities over which they have a high degree of control--planning and market analysis, equipment purchases, the implementation of wellness programs, and staff training and education. The factors that have contributed most to successful project start-up include the availability of financial resources, cooperation with other providers, the successful recruitment and retention of health professionals, and the creation of a viable strategic plan.

Many of the hospitals that completed an activity or are ahead of schedule on all project activities had started their projects before receiving their RHCT grant awards. In particular, over half of the 1991 grantees that recruited health care professionals successfully began recruiting activities prior to receiving their RHCT grant award.

## **2. Grantees Behind Schedule**

Close to one-third of the 1991 grantees (58 hospitals) have had start-up difficulties with their projects. The project activities most frequently behind schedule are establishing new services (cited by 30 hospitals), recruiting health care professionals (cited by 24 hospitals), and purchasing equipment (cited by 21 hospitals).

Over half of the hospitals that reported start-up problems had a negative operating margin in FY 1990. We interviewed 20 of these grantees to determine whether a hospital's financial situation had affected the progress of its project. Surprisingly, none of the hospitals indicated that their financial problems thwarted their progress. Rather, hospitals indicated that two other factors contributed to their falling behind schedule on their RHCT grant projects:

(1) difficulties in recruiting health care professionals, and (2) organizational instability due to their small size.

**a. Difficulty in Recruiting Health Care Professionals**

Most of the hospitals that have experienced start-up problems have had difficulties in recruiting health care professionals. Although most of the 1991 grantees have made some progress despite these recruitment problems, some reported that recruitment problems held up the progress of their entire project. For example, a hospital in Texas that is trying to establish inpatient obstetric and gynecological services is behind schedule on all of its core project activities because the hospital has been unable to recruit an obstetrician-gynecologist. The hospital administrator does not want to renovate part of the hospital into a birthing center and purchase the necessary equipment until he has recruited an obstetrician-gynecologist who can be involved in major project decisions.

**Recruiting Challenges.** Hospitals offer various explanations for their delays in recruiting health care professionals. The most common explanation is that few health care professionals, especially physicians, are willing to practice in rural areas because of the heavy on-call burden and low salaries. The on-call burden is an especially burdensome barrier, as few rural hospitals have the financial resources to hire physicians to cover their emergency rooms, and the new physician may have only one or two physicians with whom to share the burden. Furthermore, rural hospitals perceive that the dwindling supply of primary health care professionals is a major reason for their recruitment difficulties.

Rural hospitals on the urban fringe have different recruiting problems than extremely isolated rural hospitals. *Rural urban-fringe hospitals* must recruit physicians who are willing to refer patients to the small hospital, rather than to the large, better equipped hospitals located nearby. This task is challenging but it is one that is necessary for the urban fringe hospitals' survival. For example, one rural hospital in Missouri is located only 40 minutes from a large university medical center, and thus faces the challenge of recruiting a physician who is willing to refer patients to the rural hospital, even for simple procedures. Physicians in the past have opted to refer almost all patients on to larger institutions, in order to avoid transferring the patient should more serious conditions develop and to decrease the time the physician needs to spend at the hospital. A hospital in Oklahoma faces a similar problem--recruiting a physician who will locate to its area and will agree not to refer most cases to nearby urban tertiary hospitals.

*Extremely isolated hospitals*--those that are located as much as 4 to 5 hours from a metropolitan area--cite harsh winters (many are located in Midwestern and Western states), few forms of social entertainment (excluding outdoor recreational sports), and extremely burdensome on-call schedules as the factors discouraging health care professionals from locating in their towns. A Montana hospital located in an impoverished area 6 hours from a metropolitan area reported that, realistically, it will be forced to find a physician with a missionary goal who can face the harsh winters, poverty, and extreme geographic isolation. Another isolated hospital in Illinois cites the town's small size (1,400 population), lack of amenities (no restaurants or clothing stores), and extreme geographic isolation (4 hours from

a major city), as well as the hospital's heavy on-call burden (every other night), as reasons for its recruitment difficulties.

**Addressing Staff Shortages.** To recruit health care professionals, rural hospitals commonly hire recruiting firms, advertise in medical journals, and recruit from residency programs. However, hard-pressed hospitals use an alternate strategy--downsizing rather than recruiting or recruiting foreign-born health care professionals instead of U.S.-born professionals.

Some hospitals have considered downsizing rather than recruiting additional health care professionals. One hospital in Oregon is using its RHCT grant to downsize from an acute care hospital to an ambulatory care facility in light of its currently short supply of physicians. However, the hospital has fallen behind schedule, largely because it is having difficulty convincing the community about the benefits of downsizing. Another hospital that has considered downsizing is located in an extremely isolated area of North Dakota near the Canadian border. The hospital has long found it difficult to recruit and retain physicians and is seriously considering downsizing its facility in order to alleviate this constant problem.

Many of the hospitals experiencing recruitment difficulties are opting to recruit foreign-born health care professionals when previously they may have preferred U.S.-born professionals. Almost half of the project directors interviewed indicated that their hospitals have at least one foreign-born physician on staff, and that they rely heavily on this segment of the physician market. One hospital in Illinois reported that its extreme geographic isolation has prevented it from recruiting a U.S.-born physician for more than 25 years but that it has successfully recruited foreign-born physicians to meet staff demands. In addition, a rural

hospital in Texas has been unable to start its RHCT grant project--establishing a physical rehabilitation program--because it had not been able to recruit a physical therapist. After having recruited unsuccessfully in the United States, the hospital hired a national recruiting firm, which recruited a physical therapist from Egypt for the hospital. This hospital's ability to retain this physical therapist will be key to the project's success.

**b. Organizational Instability Due to Small Size**

The small size of rural hospitals leads frequently to organizational instability, thus affecting the progress of projects at many of the hospitals. Hospitals reported being behind schedule on their projects because of staffing changes that were either beneficial (for example, the hiring of an experienced administrator or an extra health care professional) or disruptive (the loss of a physician or bickering among physicians). Strategies to cope with project progress difficulties varied widely in accordance with the specific circumstances of the hospital.

A grantee from Kansas illustrates this problem. This grantee recently ceased operations as an inpatient facility because its only admitting physician left the area, first for Desert Storm, then permanently. Another physician had a practice in town, but the hospital administrator had refused to grant admitting privileges to the physician. The facility reopened as a rural health clinic with a new, experienced administrator, who hired a physician who had to commute 2 hours one way to the clinic. Because the clinic was paying the physician for his travel time, it was losing money. Thus, the new administrator decided to hire the town's only physician, an action that was essential to establishing and stabilizing the rural health clinic.

A California grantee recently hired a new administrator and assistant administrator, who have opted to make significant changes at the management level that have in turn slowed the progress of the hospital's project. The original project goal of the hospital was to undertake strategic planning, market analysis, and managerial improvements. However, since the hospital had been operated by an elected county Board of Supervisors, the new hospital administrators determined that they could not implement this project without a hospital board of trustees. After a long negotiating process, the new administrators convinced the county supervisors that a traditional hospital board would be beneficial for the hospital, and a hospital board was to be established in spring 1992. Thus, the hiring of the two administrators changed the hospital's management structure, which slowed the project's progress.

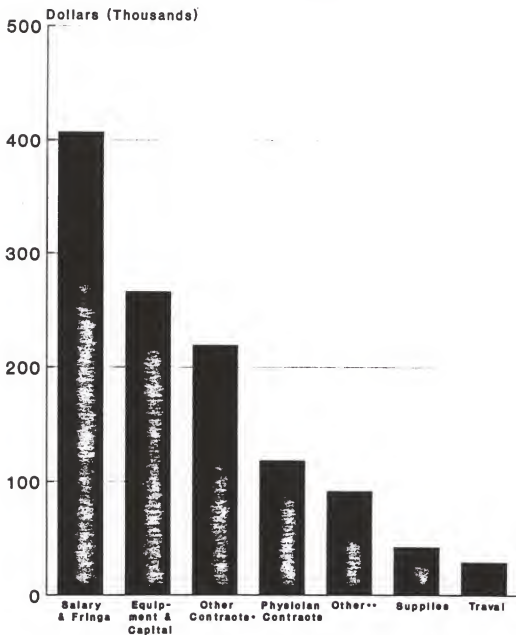
### **3. Grant Expenditures**

HCFA awarded \$8,177,255 in first-year RHCT grants to 187 hospitals in fiscal 1991. After three hospitals withdrew from the RHCT grants program, the obligated amount fell to \$8,027,255. Three months after HCFA made the awards, the 183 reporting hospitals had spent \$1,173,241, accounting for 15 percent of the obligated grant funds.

Of this percent, the hospitals spent 77 percent in the following three categories (see Figure III.3):

- Salary and fringe benefits: \$406,817 (35 percent)
- Equipment and capital: \$265,922 (23 percent)
- Non-physician contracts: \$219,046 (19 percent)

**FIGURE III.3**  
**TOTAL EXPENDITURES BY CATEGORY**  
**IN THE FIRST 3 MONTHS:**  
**1991 GRANTEES**



\* NOTE: "Other Contracts" includes all non-physician contracts like building and management.

\*\* NOTE: "Other" includes expenditures like advertising, telephone and photocopying.



This distribution is exactly the same as that reported by 1990 grantees at the end of their first year in the RHCT grants program (Cheh et al., 1991).

As might be expected, the goals of the projects influenced how hospitals use their grant funds. Projects whose primary objective is to recruit and train staff devote their funds largely to personnel expenses (salary, fringe, and travel). Hospitals whose objective is to establish outpatient services devote their funds to both personnel expenses and medical supplies expenses.

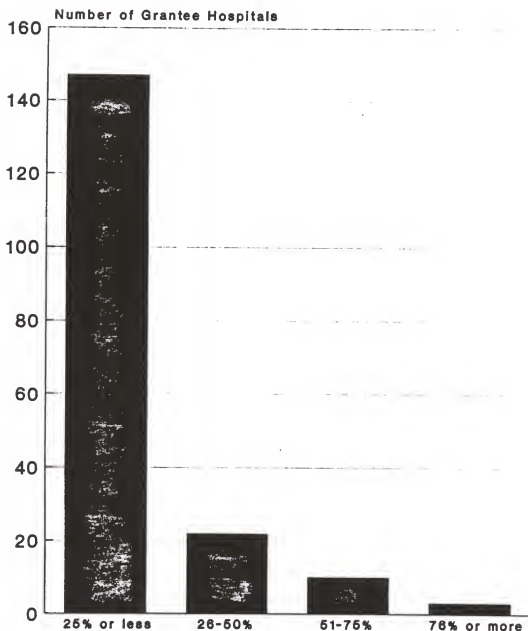
During the first 3 months, the majority of the 1991 grantees (81 percent) spent 25 percent or less of their awards (see Figure III.4). Hospitals whose projects called for new construction or conversion to another type of facility were less likely to have spent any of the first-year funds during the first 3 months.

Conversely, 3 of the 183 reporting hospitals (2 percent) spent more than 75 percent of their grant awards--and, not surprisingly, made considerable progress on their grant projects. In the first 3 months, one hospital spent 99 percent of its first-year grant award on relocating a newly recruited physician and helping set up her clinic. The second hospital spent 88 percent of its first-year grant award on salary and medical equipment to upgrade its emergency services. And the third spent 79 percent of its first-year grant award entirely on medical equipment to set up an outpatient rehabilitation center.<sup>5</sup>

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<sup>5</sup>As discussed in Chapter I, a grantee may not spend more than one-third of its RHCT grant funds for capital-related costs (Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203), Section 4005(e)). Because this hospital anticipates that all future expenses will be for noncapital items, the hospital does not violate the legislation.

**FIGURE III.4**  
**PERCENT OF TOTAL FUNDING SPENT**  
**IN THE FIRST 3 MONTHS:**  
**1991 GRANTEES**



#### **4. Project Modifications**

A few hospitals reported modifying their projects to adjust to changes in their operational environment. In several cases, the hospitals still intend to pursue their original goals but have been forced to adjust staffing configurations, site location, or program features. Other hospitals have realized their goals early and plan to expand their projects with the remaining funding.

Only two hospitals reported major changes in their goals. One hospital had planned to use its RHCT grant to convert from an acute care hospital to a primary care hospital but could not afford to maintain operations. It ceased providing inpatient care and is currently using its RHCT grant to continue with its transition to a rural health clinic.

The second hospital had planned to use its RHCT grant to expand its home health laboratory services and to provide continuing education programs for the laboratory staff. However, because the hospital has a growing need for primary health care physicians, the hospital is redirecting its RHCT grant toward recruiting and relocating primary care physicians.

#### IV. CONSORTIUM PROJECTS

Rural hospitals have joined together under different types of contractual arrangements to take advantage of economies of scale. The most encompassing of these contractual arrangements is the multi-hospital system, which provides opportunities for scale economies but requires that hospitals relinquish their autonomy. At the other extreme is the group-purchasing arrangement, which addresses only one particular scale economy but does not require that hospitals relinquish their autonomy. Between these two extremes is a consortium, or alliance, which provides a framework for hospitals to undertake joint activities but allows them to maintain local autonomy. As of January 1, 1989, 127 rural hospital consortia were operating in 43 States (Christianson et al., 1990).

Consortia are a relatively new type of organization among rural hospitals. In 1989, the average rural hospital consortium nationwide had operated for 5.7 years, and 40 percent had operated for less than 3 years (Moscovice, 1991). Among the 1990 RHCT grant winners, 60 percent of the funded consortia were established to apply for the RHCT grants program--up from 36 percent of the 1989 consortia. This growth suggests that rural hospitals increasingly view consortia as an opportunity for enhancing financial stability and are thus working to develop new alliances.

The RHCT grants program is the largest program supporting the development of rural consortia nationwide. It has awarded 41 grants to consortia since 1989. The only other national program to fund and support rural health consortia is the Robert Wood Johnson

Hospital-Based Rural Health Care program (RWJ Consortium program), which has funded the development of 14 consortia.<sup>1</sup>

The emergence of rural consortia and their potential to stabilize rural hospital revenue and maintain local access to health care services made it important to collect supplemental information on the RHCT grantees that participate in consortia. A supplemental section was sent to the RHCT grantees in consortia with the second monitoring report to ascertain the characteristics of their consortia. This chapter is based on information from that supplemental section and the second monitoring report.

## **A. PARTICIPATION IN CONSORTIA BY RHCT GRANTEES**

### **1. RHCT Consortia Grants**

Since the start of the RHCT grant program in September 1989, 41 grants have been awarded to consortia (see Table IV.1).<sup>2</sup> The number of consortium applications funded during the 3 years of the program has fluctuated, but the size of, and funding for, consortia has generally stayed the same each year. The average number of hospitals per consortium has been approximately 3.6 hospitals each year--far fewer than the 12.7 hospitals per consortium found nationwide (Christianson et al., 1990). The average amount of RHCT annual funding

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<sup>1</sup>The RWJ Consortium program began in 1988, one year prior to the RHCT grants program. Fourteen consortia were awarded development funds in the first year of the RWJ Consortium program, but only 11 projects were funded past the development stage. A preliminary evaluation of the RWJ Consortium program will be released in fall 1992.

<sup>2</sup>One consortium in Nevada received a grant in 1989. It then added an additional member and won a second grant in 1990. For the purpose of this report, these are considered to be two separate consortia.

TABLE IV.1  
NUMBER OF CONSORTIUM PROJECTS RECEIVING GRANT FUNDING

	1989	1990	1991	Total
Number of Consortia	11	16	14	41
Number of Hospitals in Consortia	40	61	48	149
Average Number of Hospitals per Consortium	3.6	3.8	3.4	3.6
Average Grant Award per Hospital per Year	\$29,853	\$31,860	\$29,076	\$30,263

SOURCE: Grantee applications.

per hospital has remained steady at approximately \$30,000 per hospital per year--\$14,000 less than the average grant of \$44,000 awarded to individual hospitals. Because the consortium projects are less expensive to the Federal Government, their relative effectiveness at ensuring financial viability will be especially important for public policy. Aiding consortium formation may prove to be a less expensive method for stabilizing the finances of rural health care institutions and maintaining local access to health care services than supporting individual hospital projects.

The most common goals of the 1989 and 1990 RHCT grant consortia are coordinating the provision of health services, providing professional education and development, and recruiting health care professionals jointly (see Table IV.2). These three goals are popular because they are positive and nonthreatening objectives in that individual hospitals can limit the amount of financial risk, and they do not threaten the local autonomy of individual hospitals. It is not surprising that these goals are also the most common among all consortia nationwide (Moscovice et al., 1991).

The least popular goal among the RHCT grant consortia is defining the market role for individual hospitals. Hospitals that offer few services and have little equipment may fear that their financially stronger, better equipped hospitals will argue convincingly that the financially troubled hospital should close--and the financially weak hospital may not want to involve other hospitals in that decision process. In addition, a marketing role agreement could be interpreted as violating anti-trust regulations. Hence, the benefits of such arrangements may not be worth their risks to individual hospitals.

TABLE IV.2  
GOALS OF CONSORTIA:  
1989 AND 1990 GRANTEES

Distribution of Consortia by Goal:	1989 Transition Grant Consortia <sup>a</sup>	1990 Transition Grant Consortia <sup>b</sup>	1989 and 1990 Combined
Coordinate Provision of Health Services	73 %	80 %	76 %
Professional Education and Development	64 %	80 %	73 %
Recruit Health Care Professionals	64 %	73 %	69 %
Joint Quality Assurance Monitoring	46 %	20 %	30 %
Advocacy at the State/Federal Levels of Government	46 %	33 %	38 %
Define Market Roles for Individual Hospitals	36 %	20 %	27 %
Share Administrative Services	27 %	60 %	46 %
Joint Purchasing of Supplies	18 %	20 %	33 %

SOURCE: Consortium Supplement.

<sup>a</sup>A total of 11 consortia reported.

<sup>b</sup>A total of 15 consortia reported.



Another relatively unpopular goal is joint quality assurance--it was less popular among the 1990 consortia (20 percent) than among the 1989 consortia (46 percent). The unpopularity of joint quality assurance among the 1989 consortia is typical; nationwide, consortia rarely pursue joint quality assurance activities due to the sensitivity of quality assurance issues (Moscovice et al., 1991). Many hospitals don't want "outsiders" involved in quality assurance for fear that confidentiality may not be maintained and that the recommendations for actions as the result of a quality problem may not coincide with the hospitals' best interest.

## **2. Participation in Any Consortium by RHCT Grantees**

Participation in consortia other than those supported by RHCT grants is less common among the 1990 grantees than among 1989 grantees (see Table IV.3). Over 24 percent of the 1989 grantees are members of non-RHCT-funded consortia, compared with 18 percent of the 1990 grantees. In contrast, only 12 percent of the rural hospitals nationwide with 300 or fewer beds are members of such alliances (Office of Technology Assessment, 1990).

The objectives pursued by the "other" non-RHCT-funded consortia are similar to those pursued by the RHCT-funded consortia, with three exceptions. First, the goal of over half of these other consortia is the joint purchase of supplies. The low proportion of RHCT consortia pursuing this goal may reflect the increased popularity of group purchasing contracts--and hence a lower demand for the newly formed RHCT consortia to meet this objective.<sup>3</sup>

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<sup>3</sup>The majority of the 1990 grantees were established to apply for the RHCT program; hence, these are newly formed consortia.

TABLE IV.3  
NON-RHCT-GRANT CONSORTIUM PARTICIPATION:  
1989 AND 1990 GRANTEES

	1989 <sup>a</sup>	1990 <sup>b</sup>
Number of Grantees That Belong to a Consortium Not Receiving Grant Funding	42	34
Percent of Grantee Hospitals That Belong to a Consortium Not Receiving Grant Funding	24 %	18 %
Percent of Grantee Hospitals That Belong to Two or More Consortia Not Receiving Grant Funding	8 %	13 %
The Objectives of Other Consortia:		
Coordinate provision of health services	45 %	68 %
Professional education and development	69 %	77 %
Recruit health care professionals	50 %	44 %
Joint purchasing of supplies	67 %	59 %
Advocacy at the State/Federal levels of government	33 %	53 %
Define market roles for individual hospitals	24 %	18 %
Joint quality assurance monitoring	29 %	27 %
Share administrative services	14 %	15 %

SOURCE: Second Monitoring Report.

<sup>a</sup>A total of 173 grantees reported.

<sup>b</sup>A total of 194 grantees reported.

Second, among the 1990 grantees, over half of the other consortia are providing advocacy support at the State and Federal levels of government. This high proportion suggests that the 1990 grantees had already joined (or had the opportunity to join) organizations to pursue advocacy objectives before they applied for a grant, and thus again there is no demand for the newly formed consortia to pursue these objectives. Third, these other consortia are much less likely to pursue the joint provision of service projects, which may reflect their fears that the Department of Justice would prosecute rural health consortias as anti-competitive--a fear that may have subsided when the RHCT grant program encouraged participation in consortia.

## **B. THE CHARACTERISTICS AND ORGANIZATION OF CONSORTIUM PROJECTS FUNDED BY RHCT GRANTS**

### **1. Characteristics**

Because consortia are such new organizations, the organizational structure of a consortium is still evolving, and the degree of structure varies widely across consortia. Relative to the 1989 consortia, the organizational structures of the 1990 consortia have slightly fewer defined coordinating roles. Twenty percent of the 1990 consortia have a lead hospital (compared with 27 percent of the 1989 consortia), and 87 percent of the 1990 consortia have a coordinator (compared with 100 percent of the 1989 consortia). This slight difference in established organizational structure is not surprising given that 60 percent of the 1990 consortia were newly formed for the purpose of applying for this grant; thus it is unlikely that they had time to establish an organizational structure (see Table IV.4).

TABLE IV.4  
OWNERSHIP AND ORGANIZATION OF HOSPITALS  
IN TRANSITION GRANT CONSORTIA:  
1989 AND 1990 GRANTEES

Characteristic	1989	1990
Number of Consortium Projects Funded by RHCT Grants	11	16 <sup>c</sup>
Distribution by Date Established:		
Established prior to RHCT grants	64 %	40 %
Established for RHCT grants	36 %	60 %
Distribution by Size:		
Two hospitals	27 %	25 %
Three to four hospitals	64 %	50 %
Five or more hospitals	9 %	25 %
Distribution of Consortia by Structure:		
Consortium has a lead hospital	27 %	20 %
Consortium has a coordinator	100 %	87 %
Distribution of Consortium Hospitals by Management Type: <sup>a,b</sup>		
Independent hospitals	76 %	80 %
Multi-hospital system	24 %	20 %
Percent Managed Under Contract	22 %	42 %

SOURCE: Consortium Supplement and First Monitoring Report.

<sup>a</sup>A total of 37 grantees reported in 1989.

<sup>b</sup>A total of 59 grantees reported in 1990.

<sup>c</sup>A total of 15 consortia reported.

Eighty percent of the 1990 RHCT consortium members are independent hospitals--similar to the 76 percent level among 1989 grantees. However, the proportion of consortium members that are managed under a management contract increased from 22 percent in 1989 to 41 percent in 1990 (see Table IV.4). This increase in contract-managed consortium members may affect the success of the consortium projects. If *all* hospitals within a consortium are managed by the same management firm, the hospitals might find it easier to work together to achieve their goals. However, we visited one consortium that consists of both independently-managed and contract-managed hospitals and whose effectiveness has been hampered by the fears of the independently-managed hospitals that the contract-management system will take them over.

The 1990 RHCT consortium members communicate frequently and effectively within their consortia. Sixty-six percent of the consortia meet once or more each month, and all of the hospitals reported that communication within the consortium is effective most or all of the time (see Table IV.5). This level of intra-consortium communication is much more frequent than found among the 1989 RHCT consortia or within the average consortium nationwide, which meets nine times per year (Moscovice et al., 1991). This high level of communication should promote success of the projects.

Non-RHCT-grant funding for the 1990 consortia is minimal; over half of the RHCT-funded consortia rely only on their RHCT grant for financial support (see Table IV.6). In contrast, only 9 percent of the 1989 RHCT consortia (one consortium) relied solely on RHCT

TABLE IV.5  
COMMUNICATION AMONG HOSPITALS IN CONSORTIA:  
1989 AND 1990 GRANTEES

Communication Measure	1989 <sup>a,b</sup>	1990 <sup>c,d</sup>
Percent of Consortia That Meet:		
More than once each week	18 %	13 %
Less than once each week but more often than once each month	18 %	33 %
Once each month	18 %	20 %
Less than once per month but more often than annually	55 %	33 %
Percentage of Hospitals Reporting That Consortium Communication Is Effective:		
Always	62 %	63 %
Most of the time	31 %	37 %
Occasionally	8 %	--

SOURCE: Consortium Supplement.

<sup>a</sup>A total of 11 consortia reported.

<sup>b</sup>A total of 39 grantees reported.

<sup>c</sup>A total of 15 consortia reported.

<sup>d</sup>A total of 54 grantees reported.

TABLE IV.6  
FINANCIAL CHARACTERISTICS OF CONSORTIA:  
1989 AND 1990 GRANTEES

Financial Characteristics	Distribution or Mean	
	1989 <sup>a</sup>	1990 <sup>b</sup>
Number of Consortia by Source of Consortium Funding:		
RHCT grant only	1	8
Dues	4	1
Revenues from joint projects	5	1
Other grants	4	2
Member support	3	5
Number of Consortia with a Set Budget	6	8
Average fiscal year budget	\$199,500	\$173,712
Minimum	\$100,000	\$33,625
Maximum	\$300,000	\$477,000
RHCT Funding		
Annual average per member: <sup>c,d</sup>	\$29,854	\$31,860
Minimum	\$5,555	\$12,500
Maximum	\$50,000	\$50,000
Annual average per consortium:	\$108,558	\$121,467
Minimum	\$37,500	\$44,833
Maximum	\$200,000	\$250,000

<sup>f</sup> SOURCE: Consortium Supplement.

<sup>a</sup>A total of 11 consortia reported.

<sup>b</sup>A total of 15 consortia reported.

<sup>c</sup>A total of 40 grantees reported in 1989.

<sup>d</sup>A total of 41 grantees reported in 1990.

grant funds, and only 24 percent of consortia nationwide receive any grant funds (Moscovice, 1991). Because 60 percent of the 1990 consortia were formed to apply for the RHCT grant, the lack of alternative funding sources is likely due to their relatively short period of time as consortia.

Over half of the 1990 RHCT consortia have an established annual budget, averaging \$173,712--approximately \$26,000 less than the average budget for the 1989 RHCT consortia and \$50,000 less than the average budget for consortia nationwide (Moscovice, 1991). The budgets for the 1990 RHCT consortia ranged from \$33,625 to \$477,000--over a tenfold difference. This level of variation is not unusual; nationwide, consortium budgets range from \$50 to \$2,000,000 (Moscovice, 1991).

The amount of RHCT grant funding also varies considerably. The average amount of first-year RHCT funding for the 1990 consortia is \$121,467--or \$31,860 per hospital in a consortium. The minimal amount of funding awarded to a consortium was \$44,832, while the maximum was \$250,000--a fivefold difference.

Competition among consortium members impedes hospitals from achieving the goals set overall by the consortium. Hospitals that compete for patients on contiguous borders may find it difficult to overcome their self-survival instincts and work jointly with competitors. Yet, for some consortium projects, such as shared mobile CAT scanner services, including geographically proximate institutions is advantageous.

Eighty-seven percent of the 1990 RHCT consortia were established on the basis of geographic proximity (see Table IV.7). Thus, it is not surprising that 56 percent of the



TABLE IV.7  
COMPETITION AMONG CONSORTIUM MEMBERS:  
1989 AND 1990 GRANTEES

Measure of Competition	1989		1990	
	Number	Percent	Number	Percent
Number and Percent of Consortium Hospitals That Compete with Other Consortium Members	23	59 % <sup>a</sup>	30	56 % <sup>c</sup>
Number and Percent of Consortia within Which Hospitals Compete	9 <sup>b</sup>	82 % <sup>c</sup>	9	60 % <sup>f</sup>
Number and Percent of Consortia Based on Geographic Proximity	8 <sup>d</sup>	73 % <sup>c</sup>	13	87 % <sup>f</sup>

SOURCE: Consortium Supplement.

<sup>a</sup>Based on 39 grantees, of whom 2 belong to 2 consortia and are counted once in each.

<sup>b</sup>Within 5 of these consortia (including 16 hospitals), 7 hospitals considered themselves to be in competition, and 9 did not.

<sup>c</sup>A total of 11 consortia reported.

<sup>e</sup>Based on 59 reporting grantees.

<sup>f</sup>Based on 15 reporting consortia.

consortium hospitals view their member hospitals as competitors. However, in six of the consortia, none of the hospitals reported being competitors with other members. Whether the projects of these noncompeting consortia are more successful during the grant period will provide important information for structuring future consortia.

## **2. Progress to Date**

After 30 months, the majority of the 1989 consortia projects have achieved some joint project goals. One consortium completed its teleradiology project, and 7 of the remaining 10 consortia reported implementing at least 1 goal. The remaining three consortia did not report any progress on joint activities and appear to be working independently of each other on their grant projects.

The consortia have made the most progress in joint education activities. Two of the 1989 consortia have conducted joint in-service education seminars, which they report will have beneficial effects on the quality of patient care. Another consortium reported significant success in its joint Licensed Practical Nurse (LPN)/Registered Nurse bridge program--18 students have completed the program, 15 students are presently enrolled, and another 200 LPNs have been in contact with the coordinator. In addition, the program has expanded to include students without diplomas or degrees who want to become LPNs.

Slow but significant progress has also been reported by a consortium that is implementing a management information system for its rural hospitals. Over the last 6 months the member hospitals have started using the general ledger component of the system, as well as experimenting with the electronic billing system. Another consortium has also implemented

a joint quality assurance system in the past 6 months. This quality assurance system took a long time to plan and implement, but the associated hospitals report that the system has worked well to date and will enable them to meet Joint Commission on Accreditation of Healthcare Organization standards.

A slightly smaller proportion of the 1990 grantees have reported significant success at implementing joint activities: after 18 months, 6 of the 15 reporting consortia report implementing joint activities, while 4 consortia are still planning their projects. Two consortia have reported progress on individual hospital activities but not on joint activities, and one consortium did not report any progress.

As with the 1989 consortia, the 1990 consortia have made the most progress in joint education programs. Three of the six consortia that reported significant progress are involved in joint education goals--one has provided in-service education to staff through the Mednet program, another has upgraded the consortium area's emergency medical technicians training, and the third has set up a joint program to train LPNs. Two of the consortia have jointly implemented services--one implemented a cardiac rehabilitation program, and the second implemented a geriatrics assessment program. Another consortium is sharing staff--a program that has significantly helped one of the hospitals address the high rate of staff turnover that it has experienced during the past 6 months.

### **C. CONSOLIDATION AS AN ALTERNATIVE TO CONSORTIUM FORMATION**

The goal of a rural health consortium is to enhance its financial viability by taking advantage of economies of scale. An alternative approach for capturing even greater scale

economies is to consolidate. By consolidating, underutilized hospitals can share the costs of building maintenance, administrative expenses, and other fixed costs, thus lowering costs and increasing profitability.

Hospital consolidation faces countless impediments, even when it is financially advantageous for the institutions involved. Hospital administrators who are likely to lose their jobs upon consolidation may staunchly oppose the move to their hospital boards. Consolidation may also disrupt access to care patterns, which hospital boards fear may disrupt patient or physician loyalty. The legal issue of institutional ownership can also be a major impediment—especially if a publicly owned hospital is involved. Finally, the cost of the legal, accounting, and other services necessary for consolidation can be considered too high for financially strained institutions, thus also deterring consolidation.

Few of the RHCT grantees have seriously considered consolidating. In any 6-month period since September 1989, only approximately 4 percent of the active 1989 grantees ever seriously considered consolidating, and only one grantee has actually consolidated (see Table IV.8). Among the 1990 grantees, as much as 8 percent of the active grantees at any point have considered consolidation, but none to date has consolidated.

TABLE IV.8  
PERCENTAGE OF GRANTEE HOSPITALS CONSIDERING CONSOLIDATION

	1989 Grantees	1990 Grantees
March 1990	4.2 %	--
September 1990	1.8 %	--
March 1991	3.8 %	7.8 %
September 1991	2.1 %	2.6 %

SOURCE: First, Second, Third, and Fourth Monitoring Reports.

## **V. ACTIVITIES FOR THE NEXT 6 MONTHS**

### **A. MONITORING**

Several monitoring activities are scheduled for the next 6 months. Grantees will submit a report to describe the progress they have made on their grant projects and the grant funds they have expended. In addition, the 1989 grantees will complete their 3-year grant projects in September 1992.

Also in the next 6 months, 25 grant sites will be visited. Fifteen of these visits will be made to 1989 grantees and 10 will be made to 1990 grantees. Telephone interviews will be conducted with 25 1989 grantees that have previously been visited, to follow up on their progress, and with 1991 grantees who have reported difficulties in implementing their projects.

### **B. REPORTS**

The Seventh Semi-Annual Report to Congress will be submitted in December 1992. This semi-annual report will once again describe the progress made by the 1990 and the 1991 grantees since their last report, based on hospital self-reports and site-visit reports. The Final Evaluation Report on the 1989 grantees will be submitted in December 1992. The Final Evaluation Report will examine the impact of the grant program on the financial stability of the recipient hospitals and their continued ability to provide services.

## REFERENCES

- Cheh, Valerie, Katherine Condon, and Judith Wooldridge. "Evaluation of the Grant Program for Rural Health Care Transition: Third Semi-Annual Progress Report." Princeton, NJ: Mathematica Policy Research, January 22, 1991.
- Cheh, Valerie, Katherine Condon, Charles Nagatoshi, and Judith Wooldridge. "Evaluation of the Grant Program for Rural Health Care Transition: Fourth Semi-Annual Progress Report." Princeton, NJ: Mathematica Policy Research, July 9, 1991.
- Cheh, Valerie, Marisa Giggie, Charles Nagatoshi, and Judith Wooldridge. "Evaluation of the Grant Program for Rural Health Care Transition: Fifth Semi-Annual Progress Report." Princeton, NJ: Mathematica Policy Research, January 27, 1992.
- Christianson, Jon, Ira Moscovice, Judy Johnson, John Kralewski, and Colleen Grogan. "Evaluating Rural Hospital Consortia." *Health Affairs*, vol. 9, no. 1, Spring 1990, pp. 135-147.
- Moscovice, Ira, Judy Johnson, Michael Finch, Colleen Grogan, and John Kralewski. "The Structure and Characteristics of Rural Hospital Consortia." *The Journal of Rural Health*, vol. 7, no. 5, Fall 1991, pp. 575-588.
- U.S. Congress, Office of Technology Assessment. *Health Care in Rural America*, OTA-H-434. Washington, DC, U.S. Government Printing Office, September 1990.

**APPENDIX A**

**1989, 1990, AND 1991 GRANTEES THAT CONTINUE  
TO PARTICIPATE IN THE RURAL HEALTH CARE  
TRANSITION GRANTS PROGRAM**



APPENDIX A

HOSPITALS CONTINUING IN THE RURAL HEALTH CARE TRANSITION  
GRANTS PROGRAM AS OF 3/15/92, BY STATE AND YEAR OF AWARD

	1989 Grantees	1990 Grantees	1991 Grantees
AL	Bibb Medical Center Fayette County Hospital Greene County Hospital Hale County Hospital	Vaughan Regional Medical Center	Cullman Medical Center Baptist Medical Center, Cherokee Valley Medical Center Bullock County Hospital, Coosa
AK	Wrangell General Hospital		Seward General Hospital
AR	Baptist Medical Center/Twin Rivers Chicot Memorial Hospital Fulton County Hospital Piggott Community Hospital Stuttgart Memorial Hospital	Booneville City Hospital Carroll General Hospital Lawrence Memorial Hospital Yell County Hospital	Cleburne Memorial Hospital Helena Regional Medical Center
AZ	Casa Grande Regional Medical Center	Carondelet Holy Cross Hospital Flagstaff Medical Center Havas Samaritan Regional Hospital Navapache Hospital Page Hospital	White Mountain Communities Hospital Southeast Arizona Medical Center
CA	John C. Fremont Hospital Lakeside Community Hospital Pioneers Memorial Hospital Redbud Community Hospital	Mayers Memorial Hospital Needles-Desert Communities Hospital Plumas District Hospital Southern Inyo Hospital Surprise Valley Community Hospital	Colusa Community Hospital Tuolumne General Hospital Southern Humboldt Community Hospital Redwood Memorial Hospital
CO	Heart of the Rockies Melissa Memorial Hospital Pioneers Hospital of Rio Blanco County Southeast Colorado Hospital	Gunnison Valley Hospital St. Vincent General Hospital	Sterling Regional MedCenter Kremmling Memorial Hospital District Mt. San Rafael Hospital
CT			Day Kimball Hospital
FL		Hardee Memorial Hospital Memorial Hospital - Flagler	Walton Regional Hospital Northwest Florida Community Hospital Campbellton-Graceville Hospital
GA	Taylor Regional Hospital Wills Memorial Hospital	Brooks County Hospital Charlton Memorial Hospital Grady General Hospital Mitchell County Hospital	Gordon Hospital

APPENDIX A (continued)

	1989 Grantees	1990 Grantees	1991 Grantees
ID	Gritman Memorial Hospital	Benewah Community Hospital Gooding County Memorial Hospital Shoshone Medical Center Teton Valley Hospital	Clearwater Valley Hospital Boundary County Community Hospital and Nursing Home McCall Memorial District Hospital Oneida County Hospital
IL	La Harpe Hospital Association Massac Memorial Hospital The Julia Rackley Perry Memorial Union County Hospital District	Carmi Township Hospital Gibson Community Hospital Hoopeston Community Memorial Hospital Paris Community Hospital Sarah D. Culbertson Memorial Hospital	Edward A. Utlaut Memorial Hospital Hardin County General Hospital
IN	Adams County Memorial Hospital Blackford County Hospital	Vermillion County Hospital	Putnam County Hospital Perry County Memorial Hospital
IA	Central Community Hospital Clarke County Hospital Mercy Hospital of Franciscan Sisters Ringgold County Hospital Stiff Medical Center	Adair County Memorial Hospital Baum-Harmon Memorial Hospital Belmond Community Hospital Buena Vista County Hospital Burgess Memorial Hospital Community Memorial Hospital Eldora Regional Medical Center Ellsworth Municipal Hospital Forest City Community Hospital Franklin General Hospital Green County Medical Center Grinnell General Hospital Guttenberg Municipal Hospital Hancock County Memorial Hospital Howard County Hospital Kossuth County Hospital Lucas County Health Center Marengo Memorial Hospital Myrtue Memorial Hospital Northwest Iowa Health Center Osceola Community Hospital Saint Joseph Community Hospital Story City Memorial Hospital	Mercy Hospital Story County Hospital Humboldt County Memorial Hospital Cass County Memorial Hospital Veterans Memorial Hospital Anamosa Community Hospital Virginia Gay Hospital Van Buren County Hospital Winneshiek County Memorial Hospital Grundy County Memorial Hospital

# APPENDIX A (continued)

	1989 Grantees	1990 Grantees	1991 Grantees
KS	Bob Wilson Memorial Hospital Salem Hospital, Inc. Wamego City Hospital	Clara Barton Hospital Graham County Hospital Hamilton County Hospital Kearny County Hospital Lindsborg Community Hospital Sabetha Community Hospital	Mercy Hospital of Independence St. Johns Hospital Coffey County Hospital Anderson County Hospital Community Memorial Hospital Arkansas City Memorial Hospital Geary Community Hospital Memorial Hospital Association, Inc.
KY	Carroll County Memorial Hospital Our Lady of the Way Hospital	Berea Hospital Marshall County Hospital and Long Term Care Monroe County Medical Center	Twin Lakes Regional Medical Center Kentucky River Medical Center Ohio County Hospital Corporation
LA	St. Helena Parish Hospital West Carroll Memorial Hospital, Inc.	Jackson Parish Hospital South Cameron Memorial Hospital West Feliciana Parish Hospital	Abrom Kaplan Memorial Hospital
ME	Blue Hill Memorial Hospital	C.A. Dean Memorial Hospital Cary Medical Center	Down East Community Hospital Maine Coast Memorial Hospital Miles Memorial Hospital St. Andrew's Hospital
MD	Garrett County Memorial Hospital	McCready Memorial Hospital	
MI	Charlevoix Area Hospital Mackinac Straits Hospital Mercy Hospital, Grayling Paul Oliver Memorial Hospital	Carson City Hospital Deckerville Community Hospital Gerber Memorial Hospital Kalkaska Memorial Health Center Kelsey Memorial Hospital Marlette Community Hospital McKenzie Memorial Hospital Mid-Michigan Regional Medical Center Sheridan Community Hospital United Memorial Hospital	Mid-Michigan Regional Medical Center Calumet Public Hospital
MN	Cook County North Shore Hospital Karlstad Memorial Hospital Kittson Memorial Hospital Northfield Hospital St. Elizabeth Hospital and Nursing Home Warren Community Hospital	Canby Community Hospital District #1 Fairmont Community Hospital Holy Trinity Hospital, Inc. Itasca Medical Center Mille Lacs Hospital Minnesota Valley Memorial Hospital North Pine Area Hospital Sioux Valley Hospital	Granite Falls Municipal Hospital Cuyuna Regional Medical Center Hutchinson Community Hospital Lakeview Memorial Hospital and Home Arnold Memorial Hospital Luverne Community Hospital St. Gabriel's Hospital ADA Municipal Hospital

APPENDIX A (continued)

	1989 Grantees	1990 Grantees	1991 Grantees
MN		St. Peter Community Hospital and Health Care Tri-County Hospital United District Hospital and Home	
MS	Leake County Memorial Hospital Methodist Hospital of Middle Mississippi Inc. Noxubee General Hospital	Choctaw County Medical Center Montfort Jones Memorial Hospital Tallahatchie General Hospital Tyler Holmes Memorial Hospital	Claiborne County Hospital Lawrence County Hospital King's Daughters Hospital Hillcrest Hospital George County Hospital
MO	Citizens Memorial Hospital Hermann Area District Hospital Moberly Regional Medical Center Perry County Memorial Hospital	John Fitzgibbon Memorial Hospital Nevada City Hospital Ripley County Memorial Hospital St. Vincent's Hospital	Pemiscot Memorial Hospital Albert M. Keller Memorial Hospital Gentry County Memorial Hospital Cooper County Memorial Hospital Sullivan County Memorial Hospital Scotland County Memorial Hospital St. Francis Hospital
MT	Broadwater Health Center Mountainview Memorial and Nursing Home St. Peter's Community Hospital Teton Medical Center	Barrett Memorial Hospital Central Montana Medical Center Holy Rosary Hospital Marcus Daly Memorial Hospital	Community Hospital of Anaconda Trinity Hospital Pondera Medical Center Big Horn County Memorial Hospital Fallon Medical Complex McCone County Hospital Prairie Community Hospital Glendive Medical Center
NE	Beatrice Community Hospital Boone County Community Hospital Great Plains Regional Medical Center Thayer County Memorial Hospital	Annie Jeffrey Memorial County Hospital Brodstone Memorial Nuckolls County Hospital Butler County Hospital Cheyenne County Hospital Association Community Hospital Garden County Hospital and Nursing Home Jefferson County Memorial Hospital	Sargent District Hospital Valley County Hospital Cambridge Memorial Hospital and Health Center Pawnee County Memorial Hospital Perkins County Community Hospital Lundberg Memorial Hospital Antelope Memorial Hospital Brown County Hospital Cherry County Hospital Niobrara Valley Hospital Osmond General Hospital Plainview Public Hospital Rock County Hospital St. Anthony's Hospital West Holt Memorial Hospital

APPENDIX A (continued)

	1989 Grantees	1990 Grantees	1991 Grantees
NV		Battle Mountain General Hospital Elko General Hospital Grover C. Dils Medical Center Mt. Grant General Hospital Nye Regional Medical Center William Bee Ririe Hospital	
NH	Cottage Hospital	The Memorial Hospital	Littleton Regional Hospital Weeks Memorial Hospital
NM	Socorro General Hospital Southwest Community Health Services	Sierra Vista Hospital	Nor-Lea General Hospital Gila Regional Medical Center Mimbres Memorial Hospital
NY	Cuba Memorial Hospital Jones Memorial Hospital Lewis County General Hospital Tri-County Memorial Hospital	Soldiers and Sailors Memorial Hospital	Canton-Potsdam Hospital Margaretville Memorial Hospital Community General Hospital-Sullivan County
NC	Ashe Memorial Hospital, Inc. Murphy Medical Center Our Community Hospital	Allegheny County Memorial Hospital Bladen County Hospital Montgomery Memorial Hospital Sloop Memorial Hospital	Charles A. Cannon Jr. Memorial Hospital Blue Ridge Hospital System Anson County Hospital Blowing Rock Hospital, Inc.
ND	Community Memorial Hospital Community Memorial Hospital Griggs County Hospital and Nursing Home Mercy Hospital Pembina County Memorial Hospital	Community Hospital in Nelson County Griggs County Hospital Jacobson Memorial Hospital Care Center McKenzie County Memorial Hospital St. Joseph's Hospital and Health Center	Presentation Medical Center St. Andrew's Hospital Kennmare Community Hospital St. Aloisius' Hospital Townier County Memorial Hospital Renville Bottineau Memorial Hospital Ashley Medical Center Wishek Community Hospital Garrison Memorial Hospital Hillsboro Community Hospital Tioga Medical Center St. Luke's Hospital Stanley Community Hospital The Mercy Hospital
OH	Highland District Hospital Pike Community Hospital	Adams County Hospital Defiance Hospital, Inc. Joel Pomerene Memorial Hospital Mercy Hospital of Tiffin, Ohio Mercy Hospital, Willard	Fostoria City Hospital Oak Hill Community Medical Center, Inc.

APPENDIX A (continued)

	1989 Grantees	1990 Grantees	1991 Grantees
OK	Arbuckle Memorial Hospital Atoka Memorial Hospital Farmers Union Hospital Association Grand Valley Hospital Lindsay Municipal Hospital Okarche Memorial Hospital Stroud Municipal Hospital	Blackwell Regional Hospital Cimarron Memorial Hospital Craig General Hospital Creek Nation Community Hospital Cushing Regional Hospital Grove General Hospital Jefferson County Hospital Memorial Hospital OMH Medical Center, Inc. Paula Valley General Hospital	Beaver County Memorial Hospital Cleveland Area Hospital Watonga Municipal Hospital Woodward Hospital and Health Center Holdenville General Hospital Harper County Community Hospital
OR	Blue Mountain Hospital Mercy Medical Center Mountain View Hospital and Nursing Home	Hood River Memorial Hospital Mid-Columbia Medical Center Pacific Communities Hospital Pioneer Memorial Hospital	Lebanon Community Hospital Mercy Forest Glen
PA	Charles Cole Memorial Hospital Troy Community Hospital	Barnes-Kasson County Hospital	Greene County Memorial Hospital
PR	Castaner General Hospital, Inc.		
SC	Union Hospital District	The Byrty Hospital	Clarendon Memorial Hospital
SD	Baptist Hospital of Winner Community Hospital Community Memorial Hospital Dakota Hospital Douglas County Memorial Hospital Freeman Community Hospital Gregory Community Hospital Landmann Jungman Hospital Pioneer Memorial Hospital St. Benedict Hospital St. Michael's Hospital	Belle Fourche Health Care Center Bennett County Community Hospital Community Memorial Hospital Custer Community Hospital, Inc. Faulk County Memorial Hospital Five Counties Hospital Hand County Memorial Hospital Hans P. Peterson Memorial Hospital Holy Infant Hospital, Inc. Marshall County Memorial Hospital Sturgis Community Health Care Center	Flandreau Municipal Hospital DeSmet Memorial Hospital Southern Hills General Hospital St. Benedict's Hospital St. Michael's Hospital Baptist Hospital Community Memorial Hospital Community Memorial Hospital Dakota Hospital Freeman Community Hospital Landmann Jungman Memorial Hospital Pioneer Memorial Hospital
TN	Claiborne County Hospital LaFollette Community Hospital Methodist Hospital of Somerville, Inc.	Baptist Hospital of Roane County Cocke County Baptist Hospital	Lewis Community Hospital Hickman County Health Services Perry Memorial Hospital

APPENDIX A (continued)

	1989 Grantees	1990 Grantees	1991 Grantees
TX	Columbus Community Hospital Crosbyton Clinic Hospital Edgar B. Davis Memorial Hospital Fisher County Hospital Hansford County Hospital District Kimble Hospital Memorial Hospital - El Campo Nocona General Hospital Palo Pinto General Hospital Shepperd Memorial Hospital	Big Bend Regional Medical Center Bowie Memorial Hospital Clay County Memorial Hospital Colorado-Fayette Medical Center Culberson County Hospital Dallam-Hartley Hospital District Eagle Lake Community Hospital Hood General Hospital Hutchison County - Golden Plains Community Hospital Jackson County Hospital District Lynn County Hospital Memorial Hospital Moore County Hospital District Parmer County Community Hospital, Inc. Pecos County Memorial Hospital Reeves County Hospital South Limestone Hospital Stonewall Memorial Hospital Ward Memorial Hospital Yoakum County	Hamilton County General Hospital Harris Methodist, Mexia DeLeon Hospital District Chillicothe Hospital District Stephens Memorial Hospital Harris Methodist, Earh County Knox County Hospital District Crockett County Hospital Pecos County General Hospital Yoakum Community Hospital Hill Country Memorial Hospital Lee Memorial Hospital Central Texas Hospital Hall County Hospital Panola General Hospital Medina Community Hospital
UT	Tooele Valley Regional Medical Center	Duchesne County Hospital	Central Valley Medical Center Gunnison Valley Hospital
VT	Copley Hospital, Inc. Gifford Memorial Hospital North Country Hospital Northwestern Medical Center	Grace Cottage Hospital, Inc.	
VA	Community Memorial Health Center Lee County Community Hospital	Southampton Memorial Hospital	Bath County Community Hospital
WA	Skyline Hospital	Cascade Medical Center Columbia Basin Hospital Dayton General Hospital Tri-State Memorial Hospital	Pullman Memorial Hospital Odessa Memorial Hospital Quincy Valley Hospital
WV	Pocahontas Memorial Hospital Sistersville General Hospital Stonewall Jackson Memorial Hospital	Broadus Hospital Association, Inc. Roane General Hospital Summers County Hospital	Sistersville General Hospital Grant Memorial Hospital Webster County Memorial Hospital

APPENDIX A (continued)

	1989 Grantees	1990 Grantees	1991 Grantees
WI	Adams County Memorial Hospital Memorial Hospital of Bosobel Memorial Hospital of Iowa County Northwoods Hospital Association Southwest Health Center, Inc. St. Joseph's Hospital St. Mary's Hospital St. Mary's Kewaunee Area Memorial Hospital	Apple River Hospital, Inc. Berlin Memorial Hospital Chippewa Valley Hospital Memorial Hospital, Inc. Prairie du Chien Memorial Hospital St. Joseph's Memorial Hospital, Inc.	Osseo Area Municipal Hospital Langlade Memorial Hospital Sauk Prairie Memorial Hospital Door County Memorial Hospital
WY	Memorial Hospital of Carbon County Memorial Hospital of Sweetwater County	Community Hospital	Iverson Memorial Hospital





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